Sheffield Hallam University | Centre for Regional Economic and Social Research

West Yorkshire Finding Independence Evaluation

Annual Report 2016

June 2016

Contents

Summary

This report summarises some of the key findings of the ongoing evaluation of the West Yorkshire Finding Independence (WY-FI) project. The evaluation combines both process and impact methods. In terms of the latter, an assessment of the impact and value-for-money of WY-FI will be conducted next year (2016/17) and will follow Social Return on Investment (SROI) principals. The intention of the process evaluation is to identify key lessons for policy and practice and support the on-going delivery of the project. During year two the focus has been on examining the operation and effectiveness of MARBs and navigator practice. **WY-FI is having a positive effect on the way in which services are being provided and experienced** by those with multiple and complex needs. The key headlines include:

The operation of the MARBs:

- MARBs have been instrumental in **facilitating service flex; getting some providers to reconsider working with those previously banned from provision; and refocussing support on the most vulnerable**. There is less evidence that this is having an impact on organisational cultures or commissioning practice.
- Significant local differences may determine the ability of MARBs to drive wider change. The MARB represents a **new departure** in areas such as Calderdale whereas there was a **strong pre-existing commitment** to joint working and similar multi-agency panels in Leeds and Bradford.
- MARBs are **resource intensive** and the long-term sustainability of the approach will depend on whether there are significant **mutual benefits** for partners beyond sharing intelligence about individual cases.

Navigator practice:

- **Outreach work** (street-based and on the premises of service providers) has been a more prominent feature of navigator practice in Bradford and Leeds.
- There is a high degree of consistency of approach across the five districts. All take a **client-led approach** and provide **tangible help** through the personalisation fund. Nevertheless, the larger teams in Bradford and Leeds may be better able to broker effective matches between navigators and beneficiaries.
- Navigators are often engaged in **long-term intensive relationships** with beneficiaries and provide a great deal of emotional and practical support. The role is emotionally draining with staff having to deal with frequent set-backs, challenging behaviour and the prospect that 'success' may be elusive. There is often a fine judgement to be made between moving people on and risking relapse. Consequently, there is an active debate in some teams about whether the role is better conceptualised as **'support worker'**.
- The positive nature of the relationships forged with participants is evidenced by the Beneficiary Insight Survey which has found that over **80% of respondents reported that their experience with a navigator was better or consistently better than expected**.
- Furthermore, **navigators have been able to improve beneficiary experiences of a range of services**. The Beneficiary Insight Survey shows that the biggest improvements in service ratings after entering into navigation have been in Health, Mental Health, Housing and Benefits.

Meeting the housing needs of people with multiple and complex needs:

- A **linear model** of housing provision prevails in the UK although there is increasing interest in Housing First approaches.

- There is strong US evidence that the **Housing First** approach is successful in enabling homeless people with complex needs to sustain independent tenancies.
- Stakeholder interviews identified a range of barriers to accessing and sustaining housing including factors associated with **supply and the allocation of appropriate housing as well as wider welfare reforms**.
- **Homeless people with mental health conditions were identified as being the most difficult to help** primarily because of the difficulties associated with accessing mental health services.
- Many stakeholders believe that **Housing First could form 'part of the mix' of service provision** but had reservations about the model and felt that it was not the only way of meeting the needs of homeless people with complex needs. A key part of the solution was the provision of other kinds of long-term supported housing as well as more flexible service provision.

Analysis of the client management information system:

- **308 service user journeys** had begun up to 14 May 2016 which included 237 beneficiaries who have ever been in the navigator caseload, comprising 163 on full navigation and 74 who had left. 71 people were in pre-navigation or case finding.
- **69 per cent of service users who have ever been in the navigator caseload had four needs;** 26 per cent had three needs. Substance misuse (98 per cent) and mental health (97 per cent) were the most commonly identified needs.
- Analysis of Homeless Outcome Star reveals that there was **a reduction in the percentage of service users who reported being stuck on each of the ten measured areas including four areas where the reduction was over 20 percentage points** (emotional and mental health; motivation and taking responsibility; drug and alcohol misuse; social networks and relationships).

Average Chaos Index scores fell from 37.0 to 30.5 and the proportion of service users reporting an improvement on all ten areas of the index was greater than the proportion reporting a worsening.

1. Introduction

The West Yorkshire Finding Independence (WY-FI) project is part of the Big Lottery Fund's Fulfilling Lives programme which aims to improve the stability, confidence and capability of people with multiple and complex needs to lead better lives as a result of timely, supportive and co-ordinated services. The intention is that beneficiaries spend less time in prison, reduce drug use, are in stable accommodation and have better mental health. £112 million has been invested in 12 projects over an eight year period. Each has a Voluntary and Community Sector (VCS) lead organisation with a strong track record of supporting those with multiple and complex needs.

DISC is the lead organisation for the West Yorkshire Finding Independence (WY-FI) project and has been awarded nearly £10 million to improve partnership working and ultimately achieve a 'systems change' in the way in which people with multiple and complex needs are supported. This Annual Report synthesises some the key findings emerging from the research undertaken during year two and focuses on:

- The operation and effectiveness of the Multi-Agency Review Boards (MARBs).
- The way in which navigators understand and carry out their role with regard to the engagement of beneficiaries and relationship building.
- Appropriate accommodation for those with multiple and complex needs.

The early sections of this report distil some of the key messages emanating from the qualitative research before considering the client management information data. The report is structured as follows:

- Section 2: Key features of the project.
- Section 3: The operation and effectiveness of the MARBs.
- Section 4: Navigator practice.
- Section 5: Meeting the housing needs of people with multiple and complex needs.
- Section 6: Data analysis.

2. Key features of the project

The focus of WY-FI is on adults with at least three needs including homelessness, re-offending, problematic substance misuse and mental ill health and who are also disengaged from services. The intention is to work with 1,050 individuals over six years across West Yorkshire with the highest number of beneficiaries in Leeds and the lowest in Calderdale reflecting the geographical pattern of need. The aim is to join up existing provision for the client group. The project is delivered by small teams of staff in each West Yorkshire district employed by a lead organisation with a strong track record of supporting those with multiple and complex needs:

- Bradford: Bridge
- Calderdale: Foundation
- Kirklees: Community links
- Leeds: Barca
- Wakefield: Spectrum.

WY-FI is overseen by a Core Partnership Management Board and has several distinguishing components:

- **Co-production** with service users.
- The deployment of **peer mentors** to provide practical and moral support to beneficiaries and demonstrate that positive change is possible.
- The use of **navigators** to help ensure that beneficiaries access the necessary support when they need it.
- **Multi-Agency Review Boards (MARBs)** that seek to facilitate multi-agency case conferencing; improve the co-ordination of service provision and ensure that services are delivered in a personalised and flexible fashion.

3. The operation and effectiveness of the MARBs

All MARBs comprised a range of service providers and commissioners and have an operational focus (see Table 1). The emphasis is on identifying cases for navigation and resolving difficulties relating to existing cases. Attendees value discussing and sharing intelligence about individual cases. Insufficient mental health representation has been an issue for some. Their presence in Wakefield and Bradford has been highly valued because it has furnished practitioners with detailed information on the nature and severity of presenting mental health issues.

Table 1: Key partners

District	Partners
Bradford	Housing Options, a local women's service, Arch (substance misuse service), Horton Housing (social housing provider), Probation, the Police (IOM), Bevan House Homeless Team, navigators and representatives from mental health services.
Calderdale	Housing Options, the commissioner of drug and alcohol services, the commissioner of Housing Support, the chair of Foundation UK, the Homelessness Service Manager, Pennine Housing (social housing provider), the Community Rehabilitation Company and Police (IOM).
Kirklees	Local authority housing solutions, the commissioner of Supporting People, Probation, mental health (assertive outreach team), Lead Navigator, Police, GP, Huddersfield Mission (support for vulnerable people), Lifeline.
Leeds	Housing Options, CRI, Forward Leeds (alcohol and drug service), Foundations (local charity), St Anne's (local charity), Leeds City Council (Strategy and commissioning), Navigators, WY-FI male engagement worker at HMP Leeds, Police, Mental Health Crisis Team and Probation.
Wakefield	Vulnerable Adult housing provider, Probation, Police, mental health (South West Yorkshire NHS), Navigators, Local Rent Deposit Scheme, Turning Point (substance misuse provider).

Significant local differences may determine their ability to drive wider change (see Table 2). The MARB represents a new departure in some areas such as Calderdale whereas there was a strong pre-existing commitment to joint working and similar multi-agency panels in Leeds and Bradford. Consequently, it has been important to establish the legitimacy of WY-FI and the MARB in Leeds by conveying a clear message that it would 'add value' and not duplicate the work of others. Whereas in Bradford the poor performance of existing panels meant that this was less of an issue. The Calderdale MARB was valued as a means of bringing agencies together and underlining messages about the need to work holistically to address client needs.

Table 2: MARBs: the local context

District	Key Features
Bradford	A commissioner is chair of the MARB which has helped to secure the active engagement of service providers. The MARB is one of a number of multi-agency panels in the city but many are perceived to be not working well. There is a dual diagnosis service that has not engaged with the MARB. Territoriality is an issue especially with some smaller CVS organisations. Adequate support services (with the possible exception of housing for those with the most entrenched problems) but a tradition of 'silo working' which means that clients fall through the gaps.
Calderdale	The MARB provided an hitherto unavailable forum for agencies to work together. There are not enough support services for beneficiaries. Senior staff ensure that it is an effective forum for resolving case issues. Providers are made aware of the multiplicity of client needs which allows them to be viewed holistically.
Kirklees	Pre-existing partnership working in Huddersfield e.g. MARAC, high intensity user group and integrated offender management team. The geography of Kirklees might make systems change more difficult. Some territoriality and defensiveness towards WY-FI: '*What makes you think you can do what we've been unable to do?'* Some agencies are unwilling to share client information. A lack of housing for people released from prison is a key issue.
Leeds	Pre-existing commitment to joint working which provides: *'a good foundation for this to happen.'* Established when similar panels were perceived to be not functioning well. A clear message was conveyed that the MARB was going to 'add value' and not duplicate the work of others. Leeds is committed to systems change and upscaling the voluntary sector. WY-FI is strategically well positioned e.g. it is part of the dual diagnosis strategy.
Wakefield	Co-location of staff has helped partnership working. WY-FI is a development of the dual diagnosis service. The BME provider infrastructure is less well developed that some other districts. This means accessing translation services can be difficult. Individuals in outlying communities are reported to be reluctant to travel to access services.

The long-term sustainability of the approach will depend on whether there are significant mutual benefits for partners beyond sharing intelligence about individual cases. Consequently, MARB partners in Bradford have provided free training on topics such as 'legal highs' and mental health. The approach has also been adopted in local efforts at working with sex-workers. MARBs have been instrumental in facilitating service flex; getting some providers to reconsider working with those previously banned from provision; and refocussing support on the most vulnerable. There is less evidence that this is having an impact on organisational cultures or commissioning practice. The innovative nature of the intervention in Calderdale coupled with a less complicated landscape of delivery and the seniority of attendees may be more

conducive to driving change in both organisational cultures and commissioning practices.

4. Navigator Practice

The way in which beneficiaries are engaged and the nature of the first conversations conducted by navigators may be crucial for subsequent experiences. The indications are that outreach work (street-based and on the premises of local service providers) has been a more prominent feature of navigator practice in Bradford and Leeds. This is a more effective conduit to those alienated from service provision but it is often more time consuming and challenging than relying on referrals. However, outreach work in Leeds has been complicated by the local authority's emphasis on enforcement.

Navigators have small, but increasing, caseloads and the freedom to work intensively with individuals over long periods of time. There is a high degree of consistency of approach across the five districts. All take a client-led approach and provide tangible help through the personalisation fund to demonstrate good faith and ability to deliver. Nevertheless, the larger teams' in Bradford and Leeds may be better able to broker effective matches between navigators and beneficiaries. Navigators are also mindful that conversations are conducted in spaces conducive to clients 'opening-up'. This has included cafes and during car/pedestrian journeys.

Navigators are often engaged in long-term intensive relationships with beneficiaries and provide a great deal of emotional and practical support. The role is frequently emotionally draining with staff having to deal with frequent rejection, challenging behaviour, setbacks and the prospect that 'success' may be elusive (see Table 3). The nature of client relationships means that there is a fine judgement to be made between moving people on and risking relapse. Consequently, there is an active debate in some teams about whether their role is better conceptualised as 'support worker'.

Disengagement from support was not viewed as a significant issue in most areas. Sporadic engagement was, however, much more prevalent and was viewed as inevitable when working with those with multiple and complex needs. The lengths that navigators were prepared to go to maintain contact, such as tracking participants down in prison, were often viewed as a key distinguishing feature of WY-FI. Similarly, a more relaxed approach e.g. not requiring beneficiaries to sign formal commitments about the frequency of contact can be instrumental in facilitating client re-engagement.

The WY-FI Beneficiary Insight Survey administered by Experts by Experience and Peer Mentors suggest that navigators are having a significant positive impact on the lives of participants. Thirty responses were received from beneficiaries that had been in navigation for a minimum of six months and who had also completed a minimum of two NDT Assessments and Housing Outcome Star self-assessments. The key findings include:

- Over 80% of respondents reported that their experience with a navigator was better or consistently better than they expected.

- Over 95% of respondents agreed/strongly agreed with the following statements: 'My navigator is someone I am confident with'; 'Working with my navigator has given me support when moving from one service to another'; 'Working with a navigator helps me to overcome obstacles to achieving what I want for myself'.

- Navigators have been able to improve beneficiary experiences of a range of services (see figures one and two). The survey shows that the biggest

improvements in service ratings after entering into navigation have been in Health, Mental Health, Housing and Benefits.

Table 3: Navigator Practice

District	Key Issues
Bradford	The team emphasised the importance of 'personality' and 'being yourself' in order to connect with clients. Time and consistency of support are vital as clients often have been alienated from other services. The process of identifying priorities is largely client-led although navigators will persuade beneficiaries to reconsider priorities if they are not addressing their most significant needs. Navigators are encouraged to 'debrief' with colleagues and line managers after challenging situations to minimise stress and share responsibility.
Calderdale	Time, not 'overpromising' and delivering were important factors in building trust and rapport. The team emphasised the importance of resilience in dealing with those whose circumstances worsen. Some service providers have not fully understood the role of WY-FI which was likened to 'a free taxi service'.
Kirklees	Personal qualities (patience, empathy, resilience) were regarded to be more important than professional expertise. Fostering autonomy and challenge is increasingly important the longer the beneficiary has been involved with the project.
Leeds	There is no consensus about how to define the role: *'If were just navigators you're navigating into services but before you're doing that, you're dealing with a lot of emotional stuff…are we support workers or are we navigators?'* Exiting beneficiaries is fraught with difficulty: *'These people haven't engaged with anybody, so when they're engaging with use that's the first people they've engaged with and then we're going "right we're going to move you on".* Resilience is vital since the work of navigators can be emotionally draining with professionals having to cope with rejection, setbacks and the prospect that 'success' may be barely discernible or elusive. Supervision plays a key role in managing the demands of the job.
Wakefield	Staff view themselves as 'support workers' and befriend individuals but the danger is that: *'You take on their chaos'*. Some clients may become reliant upon this unequal relationship and eschew taking any responsibility. There is a fine judgement to be made between facilitating independence and risking relapse: *'If we pull support away too quickly they may relapse'.* Some beneficiaries are manipulative and may view WY-FI as a *'taxi to services'*.

Figure 1: Service ratings before entering navigation

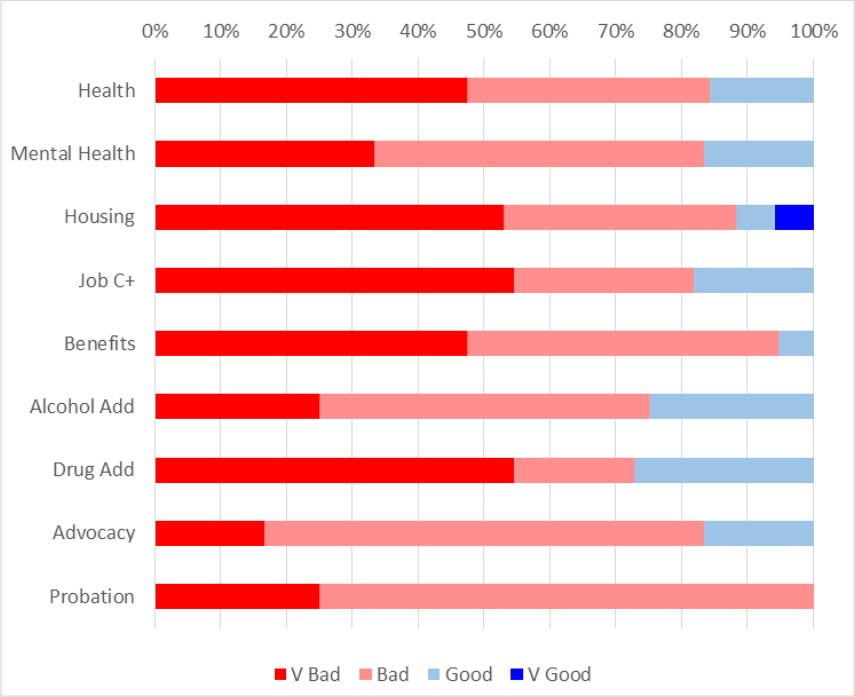
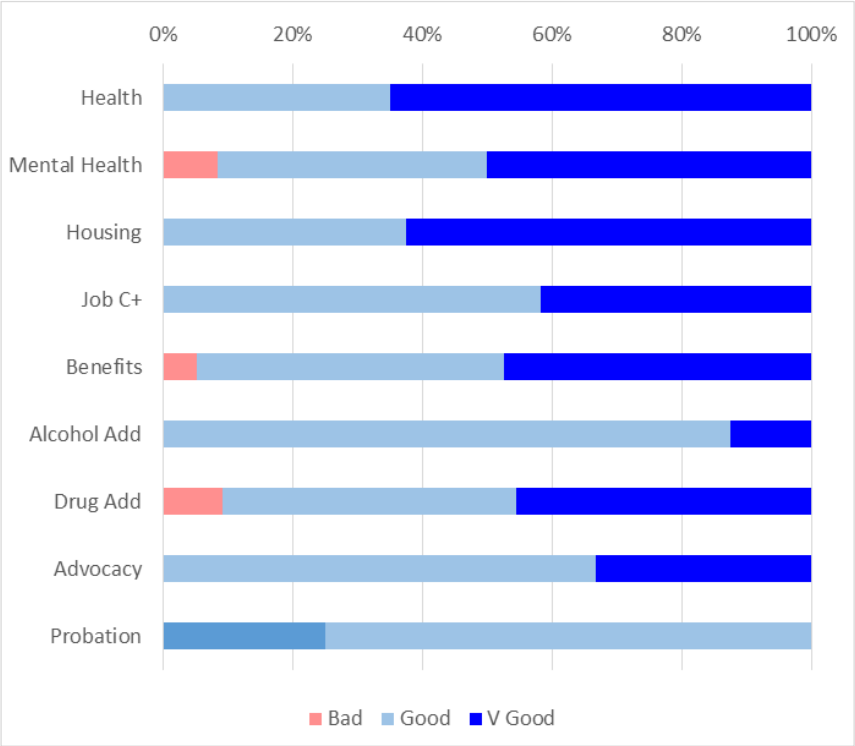


Figure 2: Service ratings after entering navigation



5. Meeting the Housing Needs of Homeless People with Complex Needs

Introduction

The majority of homeless people are socially excluded and living in vulnerable situations. Those with complex needs or who are multiply disadvantaged face the most difficulties in accessing and sustaining independent housing. For this group, homelessness is not just a housing issue but something that is closely linked with a range of other issues each of which interact with one another. These are people who have experienced what is referred to as Multiple Exclusion Homelessness (MEH). This concept refers to those who have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following other 'domains' of deep social exclusion: 'institutional care' (prison, local authority care, mental health hospitals or wards); 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work) (Fitzpatrick et al, 2012). There are estimated to be around 58,000 people each year in England who are in contact with homelessness, substance misuse and offending services and who experience multiple and complex needs (Bramley and Fitzpatrick, 2015).

It is argued that current models of homelessness accommodation do not always meet the needs of MEH, with the housing and homelessness careers of people with complex needs characterised by extreme housing insecurity as well as inadequate support. A key factor is insufficient provision, including move-on accommodation. Ostensibly settled accommodation can also prove very fragile as a result of e.g. reliance on the private rented sector which does not always comply with legal obligations or good practice (Reeves et al, 2009). It might be the case that services are delivered in a way which does not work for the client (e.g. dependent upon keeping set appointments, mixed instead of single sex). While certain groups are automatically excluded (drug users, offenders) from some temporary and supportive accommodation. The two biggest reasons for accommodation based services declining referrals or refusing access to clients in 2014 were either that the person was assessed as being too high risk to other clients or staff (77%) or that their needs were too high (76%) (Homeless Link, 2015). The multi-factorial needs faced by this homeless population are also often not adequately addressed by the silo-based services which respond to an element of individual difficulties but cannot provide an adequate response to all of the presenting issues. Related to this, 'joint working' around multiple exclusion homelessness is not always well-understood or effective and some people can find themselves bounced between different services or left out in the cold (Cornes et al, 2011).

There have been calls at the national level for the development of more effective approaches to housing this group and to address the system failure of traditional accommodation and support models (DCLG, 2015; Homeless Link, 2015; St Mungo's, 2009). This has prompted stakeholders in the homelessness sector to look to new housing models, to see what might be learned regarding better meeting their needs. This section of the report assesses the evidence regarding the effectiveness of different models of supported housing for homeless people with complex needs. It begins with an overview of the nature of MEH.

The Nature and Causes of Multiple Exclusion Homelessness

The Economic and Social Research Council (ESRC) commissioned a programme of research in the UK on MEH with the aim of informing government policy and practice and finding solutions to bring the most vulnerable 'homeless people' in from the margins of society. It comprised four separate studies which were synthesised in one final report (McDonagh, 2011). A core part of this programme was Fitzpatrick et al's

(2012, 2011) study which interrogated the nature and causes of MEH in the UK, drawing on a multi-stage quantitative study in seven cities. A wide range of homelessness and other 'low threshold' services (e.g. drug and alcohol services, services for ex-offenders and street sex workers) were randomly sampled in the seven cities. In terms of prevalence, they found the following:

- MEH service users were predominantly male (78 per cent) and were concentrated in the middle age ranges (approximately half of MEH service users were 30–49 years old).
- The most common form of substance misuse reported (by almost two-thirds of respondents) was alcohol problems, but experience of hard drug use was also noted by nearly half of service users.
- Prison was the most common form of institutional care experienced, although the level of admission to hospital with a mental health issue was also strikingly high.
- Over half of service users had been involved in street drinking, and survival shoplifting and begging were also common forms of street culture activity.
- The most widely reported adverse life events were breakdowns in relationships with parents or partners. Anxiety and depression was extremely widespread and almost four in ten service users reported having attempted suicide at least once, with approaching one-third having engaged in deliberate self-harm. Being a victim of violent crime was reported by a large minority of respondents and one-quarter admitted to having themselves been charged with a violent criminal offence.

Factors associated with more complex and extreme MEH experiences, other things being equal, included:

- being male;
- being aged between 20 and 49 years old;
- having experienced any of the following as a child: physical abuse or neglect;
- sometimes not being enough to eat at home, or homelessness;
- having parents with problems such as domestic violence, substance misuse or mental health issues;
- having had poor experiences of school (i.e. truancy, exclusion, victim of bullying);
- having lived on welfare benefits for most of your adult life;
- being recruited to the study from a 'non-homelessness' service.

Statistical clustering techniques were employed to investigate whether there were particular sub-groups within the MEH population with similar sets of experiences. This identified five key clusters:

- ***Cluster 1 – Mainly homelessness:*** these cases were the least complex overall (five experiences on average) and therefore less likely to report experiences additional to homelessness. They were overwhelmingly male (84%) and mainly aged over 35. This cluster accounted for nearly a quarter of those who participated in the survey.
- ***Cluster 2 – Homelessness and mental health:*** these cases displayed moderate complexity (nine experiences on average) but a key feature was experiences associated with mental health problems: 86% reported experience of anxiety or depression and 51% had attempted suicide. Cluster 2 was disproportionately female and accounted for over one quarter of the survey population.

- ***Cluster 3 – Homelessness, mental health and victimisation:*** this smaller group (9% of the survey population) was a much more complex and severe version of Cluster 2 (15 experiences on average). Mental ill health was a defining characteristic: experience of anxiety or depression was reported by 100%; suicide attempts by 91%; being admitted to hospital with a mental health problem by 89%; and 75% had self-harmed. Members had also experienced exceptionally high levels of victimisation – 71% had been a victim of violent crime and 40% had been a victim of sexual assault as an adult. Nearly half (48%) had been in local authority care as a child. This group was slightly younger than the MEH population average.
- ***Cluster 4 – Homelessness and street drinking:*** this smaller group (14% of the sample) comprised a moderately complex set of cases (eleven experiences on average). The defining experiences of this older, mainly male, group was street drinking (100%); rough sleeping (98%); and problematic alcohol use (96%). Other indicators of street culture activities were also common.
- ***Cluster 5 – Homelessness, hard drugs and high complexity:*** this accounted for one quarter of MEH service users and was the most complex (16 experiences on average). The defining experience was hard drug use (100%), with very high scores generally on the substance misuse and street culture domains. 21% of this group reported involvement in survival sex work (almost all of them women). Anxiety/depression was almost universally experienced (95%), and rates of attempted suicide and self-harm were also high (56% and 47% respectively). Experience of prison was very prevalent (77%). Over half had been both a victim (56%) or perpetrator (51%) of violence. Cluster 5 members tended to be in the middle age range; most were in their 30s.

Fitzpatrick et al (2012, 2011) also looked at the sequencing of experiences. Four broad phases within individual MEH experiences were identified:

- ***Stage 1 – Substance misuse:*** abusing solvents, glue or gas; leaving home or care; using hard drugs; developing a problematic relationship with alcohol and/or street drinking.
- ***Stage 2 – Transition to street lifestyles:*** becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the victim of a violent crime; sofa-surfing; and spending time in prison.
- ***Stage 3 – Confirmed street lifestyle:*** sleeping rough; begging; and intravenous drug use. Being admitted to hospital with a mental health issue also tended to first occur in this phase, as did becoming bankrupt and getting divorced.
- ***Stage 4 – 'Official' homelessness:*** These experiences included the more 'official' forms of homelessness (applying to the council as homeless and staying in hostels or other temporary accommodation) and the remaining adverse life events (being evicted or repossessed and the death of a partner).

The study also found that the roots of many people's experiences of MEH frequently lay within very troubled childhoods including school and/or family problems, sexual or physical abuse, homelessness or neglect. While this does not imply that all people with these childhood experiences will have complex lives or become homeless, such factors have a pervasive impact on an individual's life course. Fitzpatrick et al (2012) recommend that service providers working with people experiencing MEH should be alert to the probability that most of their clients will have experienced a range of forms of trauma in childhood, and a large proportion may have exhibited extreme forms of distress in adulthood (such as attempted suicide or self-harm) without the agencies necessarily being aware of this. As such, they suggest that the development of 'psychologically-informed' service environments should be a priority.

Housing Models: the evidence base

A study by Johnsen and Teixeira (2010), assessed existing evidence regarding what 'works' for homeless people with complex support needs and drew together 'lessons learned' in other developed countries. It involved a review of international literature and a series of interviews with 19 key stakeholders in the UK, US and Australia. The following section draws mainly on the findings from this study.

Johnsen and Teixeira (2010) caution that the evidence base regarding housing interventions for MEH is limited in terms of its scope and rigour and is imbalanced with the bulk drawn from US Housing First research. In the UK, there is a lack of large-scale longitudinal research in the homelessness field and/or rigorous independent evaluations of service interventions for homeless people with complex needs.

Linear Housing Models

The predominant approach to housing homeless people in the developed world is described as 'linear' in nature. The US 'continuum of care' model is the most well-known and involves 'progressing' homeless people through a series of separate residential services (emergency shelter programmes, transitional housing and supportive housing) towards independent living. Similarly, the 'staircase' metaphor has been used to describe housing systems in Sweden where an individual's housing becomes progressively more 'normal'. Both of these models are founded on a 'treatment first' philosophy which requires detoxification and sobriety before enabling access to independent housing. In Johnsen and Teixeira's (2010) study, the strengths of the linear approach highlighted by stakeholders included:

- an ability to monitor changes in clients' clinical status and/or willingness to address underlying issues and amend levels of support accordingly;
- a tangible sense of progression or reward associated with a move to 'better' accommodation; and
- inspiration fostered by witnessing fellow residents make positive lifestyle changes and successfully progress into more independent accommodation.

Stakeholders also acknowledged that hostel provision is not always necessarily conducive to the 'recovery' of this client group. A study by Reeves et al (2009) supports this assertion and suggests that homeless people with complex needs make frequent use of hostel accommodation but this rarely represents a route out of homelessness. Just 12 of 54 interview respondents had moved directly from hostel accommodation into their own tenancy during their housing careers. Many had stayed temporarily in the same hostel several times during their homelessness career.

The prevailing approach to housing non-statutory homeless people in the UK is linear underpinned by a 'treatment first' philosophy. Support agencies generally require evidence of a service user's capability to maintain a tenancy ('housing readiness'), before they are placed into independent settled accommodation. That said, housing pathways are implemented much more flexibly in the UK than the highly structured continuum of care and staircase models referred to above As such, Johnsen and Teixeira (2010) propose that the metaphor of an 'elevator' is more appropriate to describe the approach.

Linear approaches can work well with people who are willing to engage with rehabilitation programmes and are able to cope with shared accommodation arrangements. The effectiveness of linear models for homeless people with complex support needs is less clear however given the weak evidence base. Academics have

criticised the model however on the grounds of their high attrition rate, that is, the loss of service users between stages which is attributed to:

- the stress of constant change as clients move between projects;
- the reduction in support at each stage which may not suit people with multiple needs;
- use of standardised ('one size fits all') support programmes;
- lack of service user choice/control; and
- the ineligibility/rejection of potentially problematic clients.

According to its critics, the linear model makes little allowance for the complex realities of peoples' lives, especially as they negotiate the often *non-linear* process of recovery from addiction or mental illness. The rhetoric of social improvement and emphasis on the deficiencies of homeless people underpinning linear approaches has also been condemned.

The Housing First model

The Housing First model is founded upon a philosophy that essentially separates treatment from housing. Treatment is considered voluntary while housing is understood as a fundamental need and human right, not something that should be earned or used as an enticement into treatment. In this model, the homeless people with the most complex needs are placed directly into permanent independent tenancies, with comprehensive yet non-compulsory support. The first and most well-known Housing First programme is run by Pathways to Housing in New York City. Key elements of the model include:

- Immediate provision of independent accommodation in 'normal' private rented scatter-site housing leased by the provider.
- No requirement regarding 'housing readiness'.
- Deployment of a harm reduction, rather than abstinence, approach to substance misuse.
- Provision of permanent housing and support.
- Respect for consumer choice regarding: a) choice of apartment and furnishings; b) levels of engagement with support; and c) the location and times of contact with support workers.
- Provision of integrated and comprehensive community-based support to clients through multi-disciplinary Assertive Community Treatment (ACT) teams.
- Targeting of the most vulnerable.

Subsequent definitions and approaches to Housing First differ from the Pathways approach in two key areas: *where and how* service users are housed, and the *means* by which they are supported:

- the use of communal/congregate accommodation as opposed to (or as well as) scatter-site housing;
- greater selectivity in client recruitment (e.g. requiring evidence of willingness to engage with support);

- the lease of housing from providers that disallow drug-use on site (thus compromising Housing First's harm reduction philosophy); and
- imposition of time limitations to provision

The US evidence suggests that significantly better housing retention outcomes are achieved with Housing First in comparison to linear approaches targeted at this complex needs group. Bretherton and Please (2015) note that Housing First services typically rehouse between eight and nine out of every ten long-term and recurrently homeless people they work with. The Pathways programme sustained 80% housing retention of chronically homeless people over two years. Likewise, a 'Housing First Europe' research programme between 2011 and 2013 found that Housing First projects were delivering housing sustainment rates of over 90 per cent in Denmark, the Netherlands and Scotland and just under 80 per cent in Portugal (Busch-Geertsema, 2013). Moreover, studies comparing the outcomes of different Housing First programmes indicate that those most closely aligned with the Pathways model tend to report the best housing retention rates. The literature also indicates that Housing First is a cost-effective approach, which offsets the associated use of expensive emergency services. A systematic review of 184 publications on Housing First (Raitakari and Juhila, 2015: 173) concluded that:

> *"Housing First generates cost savings, increases wellbeing and is an effective route out of homelessness; high fidelity to Pathways Housing First is associated with better housing stability and quality of life outcomes; and there are many structural and cultural constraints to be taken into account when transferring Housing First from one locality to another."*

This evidence challenges the widespread assumption that chronically homeless people with co-occurring mental health problems and/or substance dependencies are incapable of maintaining an independent tenancy (Johnsen and Teixeira, 2010).

Reviewing the existing evidence, Bretherton and Pleace (2015) argue that Housing First services that follow a shared core *philosophy* tend to be successful in ending long-term and repeated homelessness. This core philosophy is summarised as follows:

- Offer permanent housing with security of tenure.
- Enable real choice for service users over all aspects of their lives, using a personalisation framework or an equivalent client-led approach.
- A clear focus on long-term and recurrently homeless people with high support needs.
- Using a harm reduction framework.
- Offer *open-ended*, not time restricted, access to *intensive* support with no expectation that support needs will necessarily fall steadily, or that any individual using Housing First might cease to require support.
- Separation of housing and care, i.e. access to, and retention of, housing is not conditional on treatment compliance.

Homeless Link (2015) suggest that around a third of homeless accommodation providers in the UK are using or exploring Housing First as a form of accommodation for their clients although fidelity to the Housing First model is mixed. Whilst there are some services adopting the core philosophy of Housing First, others appear to be 'Housing led' approaches due to their lower intensity of support, range and duration and targeting lower needs clients. A small number of projects appear to be more akin to floating support with independent accommodation. Projects that have parallels with but also depart from the Pathways model include London's Clearing House – the

Rough Sleepers Initiative lettings service; The Bournemouth Churches Housing Association (BCHA) Bridge project in Exeter. Johnsen and Teixeira (2010) suggest that the implementation of Housing First in the UK does not represent a paradigm shift in either practice or philosophy in the way that it did in the US. This is because the UK already has experience of placing rough sleepers directly into independent tenancies (albeit usually those with low/medium support needs), floating support provision is mainstream, harm minimisation approaches are well ingrained, and client-centred approaches are strongly endorsed by central government and local providers alike (Homelessness Link, 2015).

Pleace and Bretherton's evaluation of a Housing First pilot in the London Borough of Camden (2013) found it to be delivering good results together with their evaluation of nine services funded through the Homeless Transition Fund (2015). Their findings suggested that services showed high levels of success in reducing long-term and repeated homelessness:

- The bulk of service users (78%) were housed as at December 2014. 74% of their service users had been successfully housed for one year or more by five of the Housing First services.
- There was evidence of improvements in mental and physical health among service users. Of the 60 people completing outcomes forms, 26 (43%) reported 'very bad or bad' physical health a year before using Housing First, this fell to 17 (28%) when asked about current health. Thirty-one (52%) of the same group reported 'bad or very bad' mental health a year before using Housing First, falling to 11 people (18%) when asked about current mental health.
- There was some evidence of reductions in drug and alcohol use. Among the group of 60 service users completing outcomes forms, 71% reported they would 'drink until they felt drunk' a year prior to using Housing First, falling to 56% when asked about current behaviour. When asked about illegal drug use, 66% of the same group reported drug use a year prior to using Housing First, falling to 53% when asked about current behaviour.
- There was some positive evidence around social integration with neighbourhoods and with re-establishing links with family. Among the 60 service users who anonymously shared outcomes data with the research team, 21 (25%) reported monthly, weekly or daily contact with family a year prior to using Housing First, rising to 30 (50%) when asked about current contact.
- Anti-social behaviour appeared to have fallen. Of the 60 service users supplying outcomes data, 78% reported involvement in anti-social behaviour a year prior to using Housing First, compared to 53% when asked about current behaviour.
- Gains in health, mental health, social integration, drug and alcohol use and levels of anti-social behaviour were not uniform. There was also the possibility of deterioration in mental and physical health. However, there was no evidence of increases in drug or alcohol use, or anti-social behaviour.

Service users saw the freedom, choice and sense of security from having their own home as key strengths. They also valued the open-ended, intensive and flexible support they were offered. These views about what made the Housing First approach effective were shared by service providers.

Bretherton and Pleace (2015) suggest that although the projects showed signs of success, Housing First is not a panacea and the model should not simply replace existing homelessness services, as there are alternative ways in which long-term homelessness can be reduced. They suggest that there is the potential to use Housing First in new ways, for example exploring use for specific groups of homeless people,

such as women and young people with high support needs (Gaetz, 2014). Equally, Housing First might be used as a preventative model, targeted on vulnerable individuals who are assessed at heightened risk of long-term homelessness. Homeless Link (2015) report that by far the biggest barrier to setting up a Housing First project was access to suitable and affordable accommodation in both the social and private rented sectors. This included securing social housing either through the local authority or registered social providers and persuading them to be flexible with their allocations policy.

Permanent supportive housing models

There are a range of other permanent supported/supportive housing models for homeless people with complex needs in operation, many of which are underpinned by a Housing First philosophy. However, not all supportive housing uses a Housing First approach, and not all Housing First approaches use supportive housing. The typical defining elements of supportive housing include:

- the provision of safe and secure (typically self-contained and usually permanent) rental housing that is affordable to people on very low incomes;
- the provision of support by staff with appropriate skills and expertise on-site or nearby.

PSH represents a more integrated model of housing and services for individuals with complex needs - the provision of permanent accommodation with on-site support. Supportive housing projects have been developed for a wide range of target groups. Of those accommodating homeless people with complex support needs, Common Ground's 'Street to Home' programme originating in New York is the best known. Street to Home projects establish a registry of street homeless people and prioritise these for housing with the aid of a 'vulnerability index', then accommodates targeted individuals in self-contained apartments with on-site support. In the UK, there is evidence of emergent developments in permanent supported housing for elderly homeless people with complex support needs – particularly long-term rough sleepers whose physical care needs are high but whose behaviour risks making them 'unwelcome' in general needs sheltered housing (Johnsen and Teixeira, 2010).

Again, there is a lack of robust evidence regarding the effectiveness of such models as they have not yet been subject to robust evaluation, despite their growing popularity internationally.

Specialist Transitional Accommodation

Whilst some of the developments for homeless people with complex support needs in the UK have elements of 'Housing First-ness' about them, there are a large number of specialist high support transitional housing projects. These have been specifically adapted for this group and sometimes incorporate elements of low demand programmes including, for example:

- small, high quality non-institutional accommodation with a low client: staff ratio;
- creation of individually tailored 'person-centred' support plans that take into account client aspirations;
- assertive but patient engagement that aims to overcome barriers resulting from mistrust and/or the symptoms of mental health or addiction problems; and
- employment of high quality, professionally trained and 'psychologically minded' staff who understand the complexities of clients' support needs and are not intimidated by challenging behaviour.

The Old Theatre and The Lodge in London are two examples together with the Brent Dual Diagnosis project run by St Mungo's. These projects offer high levels of support, but providers have different stances regarding the degree of 'interventionism' that should be employed and/or extent to which ongoing service receipt should be contingent upon service users' proactive engagement with the support on offer. There has not, to date, been any rigorous comparison of the relative outcomes of interventionist and non-interventionist approaches to transitional housing programmes for homeless people with complex support needs in the UK or elsewhere.

Nevertheless, the evaluation of the Complex Needs Service run by a housing association in the West Midlands suggest that three factors were key to the achievement of positive outcomes: the physical and human resources invested within the service, the relationship developed between the staff and the individuals, and the willingness for staff to work with a higher level of risk than other services (Miller and Appleton, 2015). They draw attention to the positive relationship that staff developed with clients as the key interface in the service. This reflects evidence emerging from other studies with multiply disadvantaged individuals who may have grown disillusioned with or alienated from mainstream services (Parr, 2015).

Interviews with stakeholders

The research team spoke with local practitioners working with homeless people to ascertain their views on this issue. Six people were interviewed either face-to-face or over the telephone. The interviews explored stakeholders' views regarding: whether there are any sub-groups within the complex needs homeless population who are particularly disadvantaged when it comes to accessing and sustaining housing; the barriers that prevent homeless people with complex support needs accessing and sustaining independent accommodation; the adequacy of the supply of accommodation for different group/s of homeless people with complex needs; how housing services for complex needs homeless groups can be improved; the strengths and weaknesses of the Housing first model; the challenges associated with introducing Housing First services for homeless people with complex support needs. Given the small number of interviews conducted, the views expressed should be regarded as indicative.

The housing needs of homeless people with complex needs

Some of those interviewed worked within homeless services while others worked with a particular sub-section of the homeless population in specialist services such as sex workers and those involved in substance misuse. Not all therefore had a view on the differential needs of groups within the wider homeless population but could comment on the experiences of specific groups. Homeless people with mental health problems were however highlighted by most as a prominent and particularly vulnerable sector of the homeless population. It was suggested that up to 70% of the homeless population in Wakefield could be described as having complex needs. Within this group, homeless people with mental health conditions were identified as the most common sub-group followed by those with substance misuse issues and ex-offenders. While it is likely that the nature of the homeless population will vary between localities as will the disadvantages they face in accessing housing, **meeting needs of homeless people with mental conditions** was raised by most interviewees as a significant problem. This is largely because of issues around access to mental health services rather than housing *per se* (see below).

The supply of appropriate housing is not a pressing issue in Leeds: *"we're lucky in Leeds with housing".* A range of specialist housing provision was mentioned including the Crypt and the Newsam Centre. That said, one interviewee pointed to the lack of appropriate **accommodation for street-based sex workers with complex needs** in

Leeds. Barriers for women leaving prison were highlighted such as the lack of appropriate temporary housing, including bail hostels, where women may be forced to live in shared accommodation together with people who they are trying to disassociate. There can be additional problems for sex workers such as hostels reporting women missing at night when they are working. It was also suggested that there is currently no specialist accommodation that offers long-term housing and wrap-around support for sex workers with complex needs.

A particular problem within less urban localities was an inadequate **supply of accommodation** meaning that homeless people with complex needs can be very hard to house. There is not only a **lack of specialist accommodation** for individuals who are homeless and have complex needs but also a **small private rented sector** with no local history of shared housing. The latter means that there is subsequently a great deal of competition for housing which means that landlords can 'pick and choose' tenants. Private landlords have three priorities - rent paid, properties looked after and no disruption to neighbours. It can be difficult to persuade landlords to house individuals with complex needs unless they can be adequately indemnified for damage. The properties on offer from private landlords who will house this group tend to be very poor quality. One interviewee explained that individuals with complex needs living in other parts of Calderdale (e.g. Todmorden and Hebden Bridge) can often find it difficult to find accommodation in these more expensive, and less well provisioned, areas and so often end up on a housing estate in Mixenden (a deprived peripheral housing estate just outside Halifax). In these circumstances, it was suggested that WY-FI play an important role in trying to help this group navigate housing services.

In other areas, it was suggested that barriers to housing are not necessarily about supply of housing per se but about **the allocation of housing**. With regard to social housing, landlords want to know that a tenancy is sustainable. While they will not necessarily always exclude homeless people with complex needs they would want to know that support is in place to allow them to sustain a tenancy. For those with what was referred to as 'chequered housing histories' this makes it hard to access social housing again. One way Calderdale Council has been working to overcome this reluctance is to offer larger Bonds (up to £1,500) in cases where tenants are more likely to be disruptive. However, social housing still remains a challenge because of arrears that may automatically disqualify them as well as the responsibility towards existing tenants and staff that may preclude housing some individuals.

Two interviewees drew attention to recent **welfare reforms** that have fundamentally affected people's ability to access housing and have made it particularly hard for complex needs groups. Interviewees drew particular attention to capped LHA rates for single people under 35, the 'bedroom tax' and the 4% reduced housing association rents. The effects of the current system were described by one interviewee as an 'avalanche'.

A number of interviewees also suggested that a key issue for people with complex needs is not just about accessing accommodation per se but finding a suitable property with a location in which **the wider community** can peacefully co-exist. One interviewee framed this as being about strategies to promote community cohesion.

Views on different housing models

Some interviewees were able to identify the strengths and weaknesses of different housing models. One interviewee identified the **strengths of the linear model** as operated by the Basement Recovery Project which has seven of its own shared houses (one of which is for women only). Housing is provided on a linear model with different levels of support for clients at different stages of the recovery journey to independence. 'Stage 1' housing (The Community Detox Centre) has 24/7 staff support, a detox

manager and a team of volunteers; Stage 2 accommodation (The Therapeutic Community Project) is made available after six months and has no support live-in staff, but there is access to a support worker; Stage 3 accommodation can be accessed after 12 months and is fully independent. All the housing options require total abstinence. The model offers housing that is structured, safe, combined with intensive support and very flexible. Basement also emphasised the importance of having housing in relative 'good' locations. The disadvantage is that the staffed houses are very expensive to run. They are currently only able to manage this using enhanced housing benefit alone (there is no contract or grant funding) by cross subsidising it. A weakness of the linear model is that it can be harder for women to sustain in the later unstaffed stages because of the on-going support the need to deal with the guilt or trauma of separation from children as well as issues presented by co-dependence on men. The interviewee also noted that their housing offer could be improved by providing more support with helping people to develop life skills.

Particular examples of **specialist housing services** for housing people with complex needs were mentioned by interviewees as effective:

- Foyers (this is however only for young people).
- The Keystone project in Oldham which has a caretaker in a flat that supports eight people.
- The Seaman's Mission in Newham. One feature was an intranet service that told residents via a television screen in their room what activities were available and when.
- The Liverpool YMCA has developed a psychologically informed environment that is based on Cognitive Analytical Theory.
- Provision has just been opened in Kirklees that has a no eviction policy and allows dogs and alcohol on the premises.

All interviewees were broadly familiar with the notion of **Housing First** although it was apparent that some aspects of the philosophy were not fully understood by some. A couple of interviewees were in the process of setting up Housing First projects and so were more knowledgeable and enthusiastic about the approach. Others however held mixed views regarding the potential of Housing First. That said, most felt that Housing First 'has a place' as part of a range of housing support options available. It was claimed that there has been a move away from hostel accommodation, particularly in Leeds, as this has increasingly been seen as ineffective. Accompanying this, it is suggested that there has been a shift to advance new models of working that move people to independent living more effectively. One example of this, described as having some characteristics of Housing First, is trainer tenancies in Bradford which are to be managed in partnership with WY-FI. Homeless people, particularly those living in temporary accommodation will be given a tenancy and ‘training’ in how to sustain it. Tenants are however going to be carefully selected and will be those most likely to be able to retain a tenancy and who might be described as 'housing ready'.

A Leeds interviewee suggested that the central tenets of Housing First chimed with their assessment of the needs of street sex workers which suggested that housing was a critical factor for women wanting to make positive changes including addressing substance abuse, reforming family relationships or (if desired) by the moving into a different form of work. The First Choice Housing Project for Sex Workers Project is aimed at a particular section of the homeless street worker population i.e. those with complex needs. These are women who are homeless and involved in street sex work but who also have a range of other social and welfare needs such as substance misuse issues, histories of domestic violence, dealing with the trauma of having had children removed and mental health concerns. From September 2016 in partnership with

Foundations, six sex workers will be housed in permanent accommodation across Leeds. There are no pre-allocated homes and the approach will emphasise choice and flexibility. As such, Foundations will work with individuals and Basis to find a suitable property and, as far as possible, within an area of Leeds in which the woman chooses to live. The service is not abstinence-based and women will not be expected to cease their involvement in street sex work. Wrap-around support will also be offered and this will be provided by Basis workers in partnership with WY-FI who are likely to be known to a number of the women.

While there was a general consensus that Housing First has something to offer, interviewees also expressed some scepticism about the approach. One interviewee suggested that the Housing First model is 'interesting' but comes with lots of 'risks' and 'loopholes'. The practical and ideological reasons for interviewees' **reservations about the model** included the following:

- The approach relies on housing stock to be made available in the first place.
- Permanent supported accommodation is not always the best option as it encourages dependency 'when most people are capable of living independently'.
- It might not be a suitable approach for all beneficiaries. Some might have other support priorities and may not want to move into their own accommodation. A client-led approach may mean other issues are prioritised: "housing might be the last thing they want".
- Social integration and isolation. The properties might not be in the right locality to meet the needs of the beneficiary. Likewise, the needs of the community need to be taken into account and many will not tolerate ‘problem’ populations.
- Potential recipients may have to be 'cherry picked'; Housing First will not work for everyone.
- If the clients are not receiving housing benefit how will rent be paid?

The improvement of services

There was more enthusiastic support for the **introduction of flexible admissions and exclusion criteria** in temporary accommodation as a means of improving access to housing for homeless people with complex needs. This might include providers reviewing thresholds, policies around exclusions, and operating more flexible admissions criteria to remove barriers to access, as well as the relaxation of time-limits associated with temporary housing. One interviewee claimed that the situation has in fact already improved to some degree since the introduction of WY-FI firstly as navigators have successfully assisted particiants to re-engage and navigate access to support services but also because the MARB has help initiate service flex and encourage services to deliver in a different way through more effective partnership working around this client group. While WY-FI was deemed very important in the current context, one interview raised the issue of WY-FI's legacy particularly with regard to the ongoing need for navigators.

A Calderdale interviewee felt that there needs to be a **'menu' of new provision** offering intensive support to fill some of the existing gaps. They felt that there is a particular need for housing that offers 24/7 live-in intensive support for individuals with the most complex needs and that there are lessons from the YMCA project in Liverpool. It was also reported that there is a need for less intensely supported accommodation in line with the model currently being developed by Horton Housing intensive management. However, it was claimed that there are not sufficient resources to support the development of these kinds of intensive provision, especially as funding for supported housing is currently in limbo. The ideal solution would be staffed and

supported units that can flex in who they take on and that are designed to be 'less easy to trash'. There would also be a need to find an organisation that has the capacity and staff expertise to work with this client group.

Mental health services

This was raised as a key issue in all localities and is a particular problem because of both **long waiting lists** and the associated difficulty in getting a diagnosis but also because of high mental health **service qualification thresholds**. One interviewee suggested that in order to qualify for a community mental health service (e.g. CPN) an individual must be diagnosed with a severe and enduring mental health condition. However, homeless services are reported to commonly be seeing people with other conditions such as personality disorders, which are often framed as low-level meaning they do not qualify for support. Nevertheless they have a serious impact on a person's ability to access and maintain a tenancy. The issue of **dual diagnosis** and the ability of those with substance misuse and mental health problems to engage with services because of the exclusion criteria of some services was also raised as a barrier e.g. mental health services often will not provide support to somebody if they have been drinking or using drugs. One interviewee reported that the biggest barrier to achieving outcomes with the target group is mental health services not housing.

Key points

- Within the UK, a linear model of housing provision for homeless people with complex needs prevails although there is increasing interest in Housing First approaches with recent examples of trials and pilots of the model.
- There is strong evidence from the US that the Housing First approach is successful in enabling homeless people with complex needs sustain independent tenancies.
- Interviews with stakeholders indicate that there are a range of barriers to accessing and sustaining housing that complex needs homeless people face. This includes factors associated with the supply and allocation of appropriate housing as well as wider welfare reforms.
- Homeless people with mental health conditions are the most difficult to help primarily because of the difficulties associated with accessing mental health services.
- Most stakeholders interviewed believe Housing First could potentially form a beneficial ‘part of the mix’ of service provision but had reservations about the model. A key part of the solution was also the provision of other kinds of long-term supported housing as well more flexible service provision.

6. Data analysis

A central strand of the evaluation is an assessment of the Impact and Value for Money of WY-FI. This will be conducted following Social Return on Investment (SROI) principals. The most important of these include: identifying and measuring change on outcome measures; adjusting measured outcome change for what might plausibly have happened in the absence of WY-FI; valuing the social, economic and financial impacts and comparing these to costs. It will also include the measurement of:

- economy: whether the WY-FI has been delivered at least cost
- efficiency: the cost per service users

- effectiveness: how effective WY-FI has been in producing outcomes and the cost per outcome.

The first full assessment of impact and value for money will take place in the forthcoming year (2016/17) when the WY-FI service has had sufficient time to bed in. The focus of the current analysis is three fold: it will document activity to date (16 May 2016), describe the characteristics of the beneficiary group and finally provide evidence on outcome change for service users in the navigator caseload. Evidence collected through WY-FI's own client management information system (MIS) underpins this section of the report. The MIS captures:

- service user level information to assist the management and delivery of WY-FI services
- information on key outputs and outcomes to demonstrate activities, impacts and value for money of the service to wider stakeholders and commissioners
- required information to feed into the national evaluation of Big Lottery Fund's Fulfilling Lives programme which is being led by CFE consulting.

Outputs

This section documents the main outputs of the WY-FI service between up to May 2016. It includes both an overview of notifications received and headline information on service user journeys and episodes: the main output measures of the WY-FI service.

Notifications

WY-FI has received notification forms for 817 individuals with presumed multiple and complex needs. Figure 3 shows when notifications were received and Table 4summarises the number of notifications received by Primary Care Co-ordinator organisation. Of the 817 notifications received partners were able to make contact with 446 individuals (55 per cent).

Figure 3: Number of notifications received annual quarter; 16 May 2016

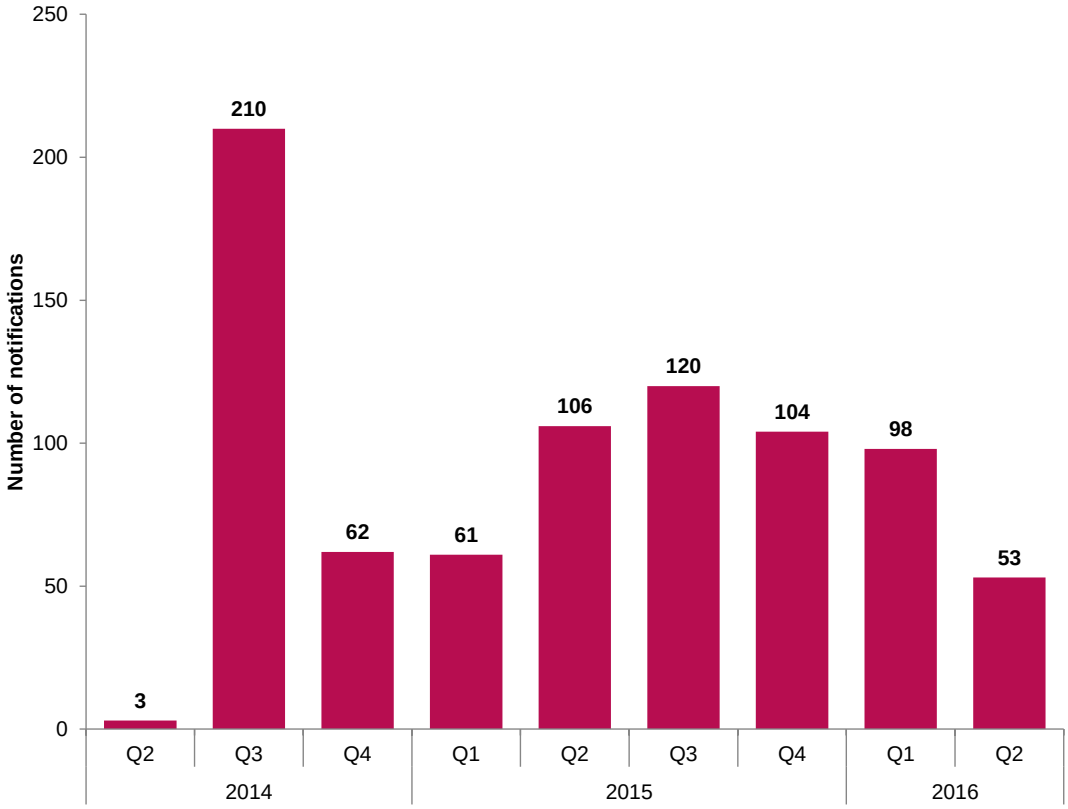


Table 4: Number of notifications received by Primary Care Co-ordinator; 16 May 2016

Co-ordinator	Number	Per cent
Barca	172	21
Bridge	156	19
Community Links	105	13
Foundation	115	14
Shelter	24	3
Spectrum	137	17
Touchstone	39	5
TWP	69	8
Total	**817**	**100**

Just under half of notifications (49 per cent; 402 notifications) were suspected of having all four needs (criminal justice, homelessness, mental health and substance misuse). A further 42 per cent (347 notifications) had three identified needs and six per cent (52 notifications) had two identified needs. Of the 817 notifications:

- 94 per cent had substance misuse needs
- 87 per cent had mental health needs
- 79 per cent had homelessness needs
- 78 per cent had criminal justice needs.

Journeys and episodes

Each service user who engaged with WY-FI has a Journey with the project. This may consist of one continuous period of involvement or a number of periods of participation. Each period of co-working on a single issue within the WY-FI service is called an episode. For example an episode may involve co-working between a navigator team and an advisor to resolve a housing issue.

As previously described a service user's journey is classified into three stages:

- **pre-navigation:** when service users first enter the service they have their needs assessed for eligibility and future requirements; they are then supported until a place is available in the navigator caseload
- **navigator caseload**: service users work with a navigator who co-ordinates their support and ensures that beneficiaries access the necessary support when they need it;
- the final stage on the journey is **post navigation** when the user has left the service for reasons including no longer needing support, disengagement or having sub-threshold needs.

By 16 May 2016, 308 service user Journeys had begun (see Table 5 which shows the number of at each stage by Primary Care Co-ordinator). On 16 May 2016:

- 9 service users (3 per cent) were in case finding
- 62 service users (20 per cent) were in pre-navigation,

- 163 service users (53 per cent) were in the navigation caseload
- and 74 service users (24 per cent) were in post-navigation.

Of the 72 service users in post-navigation, 32 individuals (44 per cent) had disengaged from project, 12 (17 per cent) no longer needed support, seven (10 per cent) had moved out of the area and three (four per cent) had died. The remaining ten cases were unknown.

The 308 service users have had 480 episodes with services; 177 individuals have had one episode, 198 individuals have had two episodes, 78 individuals have had three episodes and 27 had four or more.

Table 5: Number of service users at each journey stage by Primary Care Co-ordinator; 16 May 2016

Co-ordinator	Case finding	Pre-navigation	Navigator Caseload	Post-navigation	Total
Barca	3	22	41	33	**99**
Bridge	1	4	37	13	**55**
Community Links	4	8	19	7	**38**
Foundation	0	8	30	6	**44**
Shelter	0	6	0	0	**6**
Spectrum	1	2	30	2	**35**
Touchstone	0	5	5	5	**15**
TWP	0	7	1	8	**16**
Total	**9**	**62**	**163**	**74**	**308**

Baseline characteristics of service users in the navigator caseload

This section provides a description of the baseline characteristics of service users. It draws on data from Service User Records, Homelessness Outcome Stars and Chaos Indexes collected at the beginning of each service users' Journey. This is used to identify support needs and provide a baseline against which to measure outcome change.

Service user records

Service User Records have been created for 302 service users, including 195 of the 200 individuals who had ever been in the navigator caseload. The remainder of this section provides baseline characteristics of service users who had ever been in the navigator caseload. In particular it provides information on:

- age, gender and ethnicity
- educational attainment and needs
- housing situations
- income sources
- and an assessment of their needs.

Of the 195 clients with service user records and who had ever been in the navigator caseload 37 per cent were female and 63 per cent were male. The average age of service users who had ever been in the navigator caseload was 38. Nineteen per cent were aged 29 years and under, 36 per cent were aged 30 to 39 years, 32 per cent were aged 40 to 49 years and 13 per cent were aged 50 years or over. Eighty four per cent of service users who had ever been in the navigator caseload were White British or Irish.

This age and gender balance broadly fits the profile of individuals with multiple needs identified by a wider national study produced for the Lankelly Chase Foundation[1]. This found that the people affected are predominantly white men, aged 25–44, with long-term histories of economic and social marginalisation and, in most cases, childhood trauma of various kinds. Of course, this does not preclude the possibility that other groups are actively excluded from, or choosing not to present themselves to, services. Parallel action research on women and ethnic minorities will be important in understanding the extent of this in West Yorkshire.

Literacy problems were identified for 36 (21 per cent) of 171 service users who had ever been in the navigator caseload and data were provided.

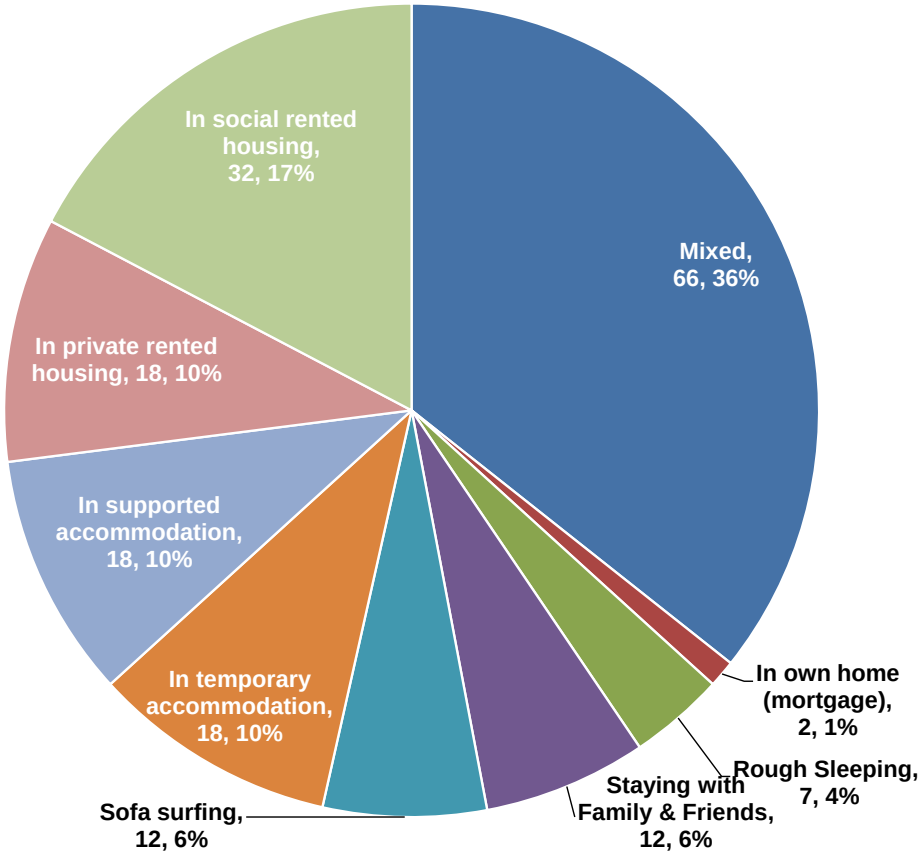
Figure 4 shows the housing situations - at their initial assessment - for service users who had ever been in the navigator caseload. This reveals a spread across a number of situations with:

- 66 service users (36 per cent) were in had mixed housing situations
- 32 service users (17 per cent) were in social rented accommodation
- 18 service users (10 per cent) were in private rented accommodation
- 18 service users (10 per cent) were in supported accommodation
- 18 service users (10 per cent) were in temporary accommodation.

Service user records also show 18 per cent of service users reported sleeping rough any proportion of the time.

[1] Lankelly Chase Foundation (2015) *Hard Edges: Mapping severe and multiple disadvantage.*

Figure 4: Current housing situations of service users; 16 May 2016



The following bullets summarise key benefits claimed by service users who had ever been in the navigator caseload:

- 133 service users (75 per cent) claimed Employment and Support Allowance or incapacity benefit
- 41 service users (23 per cent) claimed Housing Benefit
- 14 service users (8 per cent) claimed Jobseekers Allowance (JSA)
- 2 service users (1 per cent) claimed Income Support
- 43 service users (24 per cent claimed other benefits.

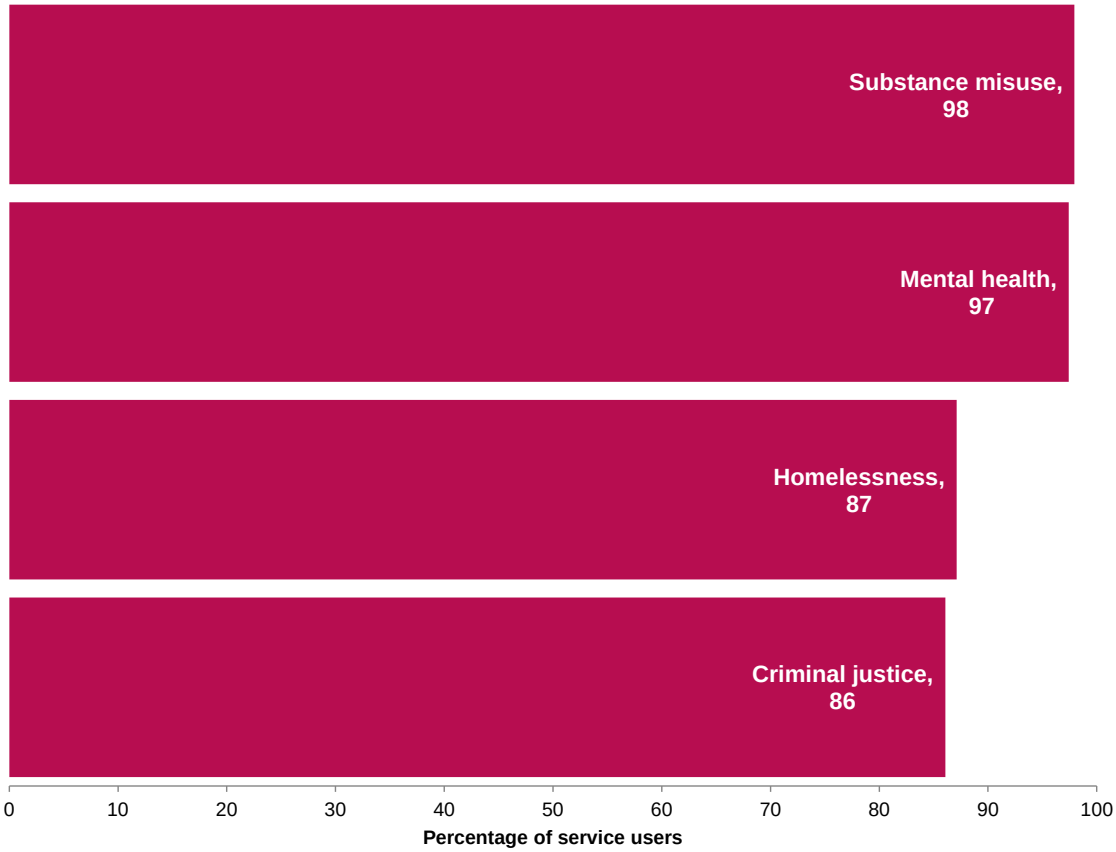
Service User Records also illustrate other key alternative income sources:

- 25 service users (45 per cent) relied on family and friends
- 19 service users (19 per cent) relied on begging
- 19 service users (19 per cent) relied on illegal activity
- 20 service users (11 per cent) relied on sex working
- 21 service users (12 per cent) relied on other sources.

Just over two thirds of service users who had ever been in the navigator caseload had all four key needs (69 per cent; 138 service users). A further 51 service users (26 per cent) had three key needs. The prevalence of the four 'WY-FI needs' suggests that this focus is appropriate, although it may also reflect a tendency to record those needs which are part of the formal threshold criteria. The following list the needs identified for service users who had ever been in the navigator caseload (Figure 5):

- 190 (98 per cent) had substance misuse needs
- 189 (97 per cent) had mental health needs
- 169 (87 per cent) had homelessness needs
- 167 (86 per cent) had criminal justice needs.

Figure 5: Percentage of service users with identified needs; 16 May 2016



Homelessness Outcome Star

Homelessness Outcome Stars have been used by WY-FI to support and evidence change when working with clients. The Star was originally developed by Triangle Consulting for St Mungo's. It has been developed through bottom-up processes, rooted in an understanding of the nature of change. It is therefore meaningful to both service users and workers, supporting the delivery of services, as well as providing robust outcomes data that reflects the aims, objectives and activities of services.

The Homelessness Outcome Star is a key worker tool: it supports the service user in making changes by providing them with a map of the journey of change and a way of plotting progress and planning the actions they need take. It focuses on 10 core areas (listed below) that have been found to be critical in supporting people to move away from homelessness.

- motivation and taking responsibility
- self-caring and living skills
- managing money and personal administration
- social networks and relationships

- drug and alcohol misuse
- physical health
- emotional and mental health
- meaningful uses of time
- managing tenancy and accommodation
- offending

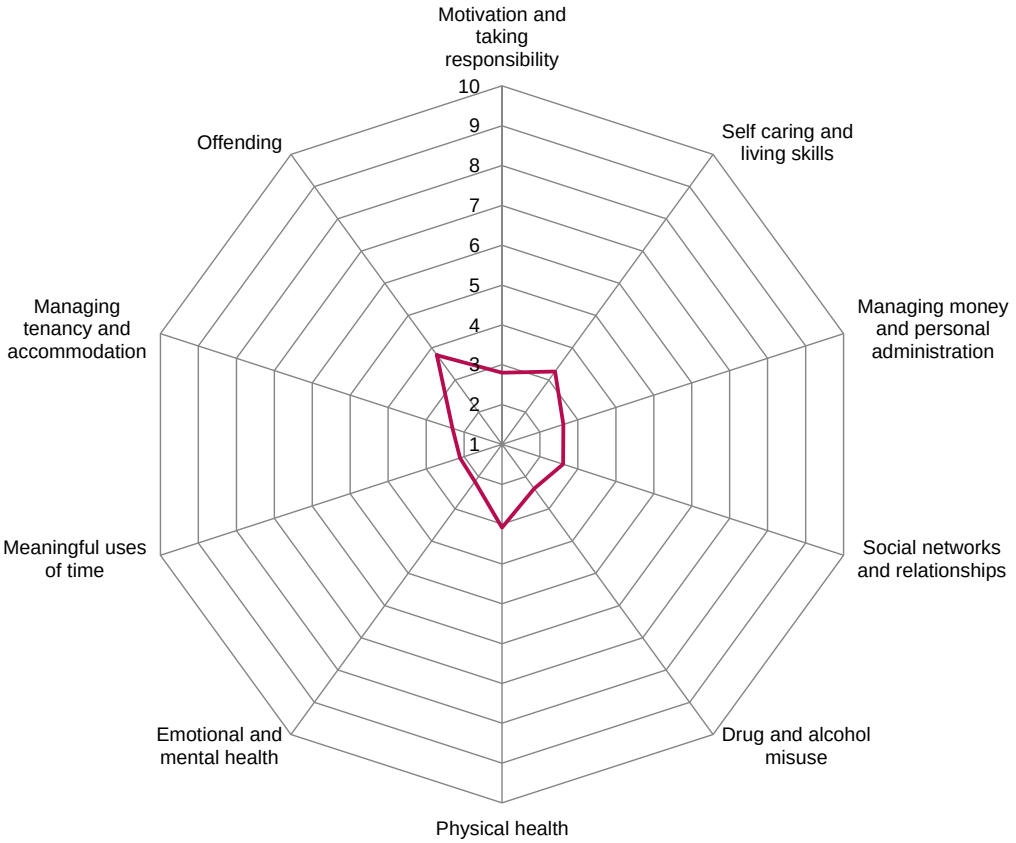
Five broad stages are identified against each area, reflecting the process by which people make changes in the areas of their life where they face challenges. The five stages are: stuck, accepting help, believing, learning and self-reliance. Within each stage there are two levels which combine to create a ten point scale. On this scale '10' indicates managing well and not currently requiring any support. Conversely a score of '1' implies they have a problem in the area but they are completely ignoring it and letting it get worse.

The process of completing the Stars involves the worker and service user discussing the ten areas and deciding where they feel the service user is on the 10 point scale. It not an exact science and scores will depend on the service user and how they see their journey of change.

Analysis of Homeless Outcome Star data illustrates the multiple needs of service users and the support required to facilitate the journey towards independence which lies ahead.

Figure 6 shows the average recorded baseline Homelessness Outcome Star scores for the 189 service users who had ever been in the navigator caseload. The average scores are fairly tight around the centre of the star. This indicates service users face deep rooted issues or needs across the 10 areas and are at an early stage of acknowledging their situations and either seeking or accepting help. Meaningful use of time had the lowest average score (2.1) and offending the highest (3.8), both of which are within the second stage of progression 'accepting help'.

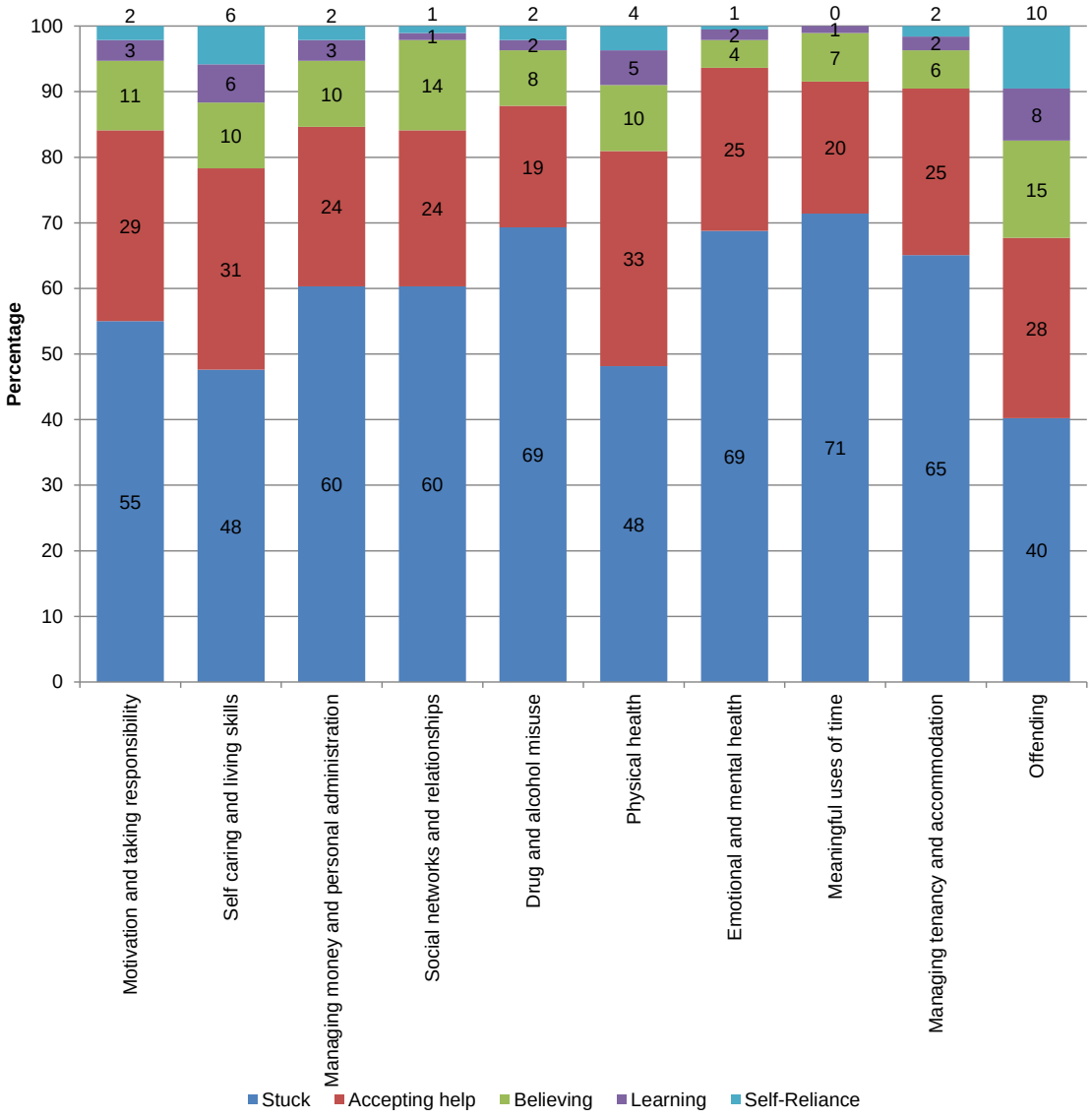
Figure 6: Average service user Homelessness Outcome Star scores at baseline assessment; 16 May 2016



The average scores hide variation across service users. Figure 7 presents a more detailed picture of the proportion of service users who had ever been in the navigator caseload at each of the five stages for each of the 10 areas. Key points include:

- 'offending' has the lowest proportion of service users classified in the first stage or 'stuck' category: 40 per cent
- over two thirds of service users who had been in the navigator caseload identified they were 'stuck' with respect to: 'meaningful uses of time' (71 per cent), 'drug and alcohol misuse' (69 per cent) and 'emotional and mental health' (69 per cent).

Figure 7: Proportion of service users at each stage of the Homelessness Outcome Star at baseline assessment; 16 May 2016



Chaos Index

The Chaos Index was originally developed by the New Directions Team in the London Borough of Merton, which was one of 12 pilots from the national Adults Facing Chronic Exclusion (ACE) Programme. It was developed to identify individuals or groups to target. The initial phase of development was to understand the different perspectives of the multi-agency steering group and who the tool would be used by; this included for example Primary Care, Housing, the Police, Jobcentre Plus and the volunteer bureau. A review was then undertaken of the research evidence about the characteristics frequently identified with people who have chaotic lives. This identified 10 areas:

- engagement with front-line services
- intentional self-harm
- unintentional self-harm
- risk to others
- risk from others

- stress and anxiety
- social effectiveness
- alcohol/drug abuse
- impulse control
- housing

Within each area a five point scale was set out against which to assess the service user. These are then combined to create an overall index score. Eight of the areas are scored on a scale from '0' to '4', whereas two areas - 'risk to others' and 'risk from others' - are on a scale running 0, 2, 4, 6, 8. In each case the lowest score reflects there are no concerns. Conversely the highest score indicates a lack, severe level or immediate risk within the given area. Summing across the 10 areas provides a score running from '0' (the lowest level) to '48' (the highest level) on a spectrum of chaos in the life of the service user.

Initial baseline assessments of service users on the Chaos Index reveal high levels across the 10 areas. The average score recorded across all services users who had an assessment and had ever been in the navigator caseload was 36.2. This score is equivalent to reporting the fourth highest level for each of the 10 areas.

Figure 8 illustrates the average level for each area for all services users had been in the navigator caseload. Note 'risk to others' and 'risk from others' have been put on a '0' to '4' scale to simplify the interpretation of the figure. The data shows the highest average scores were recorded for 'alcohol/drug abuse', 'stress and anxiety' and 'unintentional self-harm'. The average was less than the fourth highest level for 'intentional self-harm', 'risk to others', 'risk from others' and 'social effectiveness'.

The average scores hide variation across service users. For instance 16 per cent of service users who had ever been in the navigator caseload scored 43 or more out of 48 on the Chaos Index; this is equivalent to at least five scores (including 'risk to others' and 'risk from others') at the highest level and five at second highest level across the 10 areas.

Figure 9 presents a more detailed picture of the proportion of service users who had ever been in the navigator caseload at each of the five stages for each of the 10 areas. Over half of service users scored the highest level on three areas: alcohol/drug abuse (74 per cent), stress and anxiety (62 per cent) and unintentional self-harm (56 per cent).

Figure 8: Average service user Chaos Index scores at baseline assessment; 16 May 2016

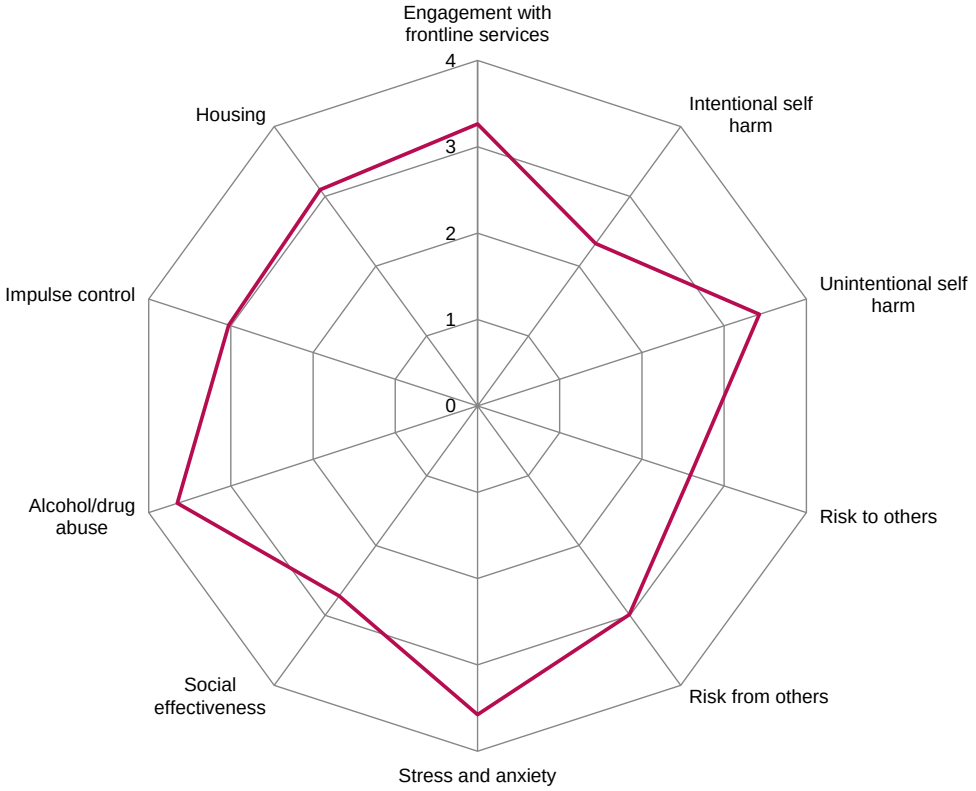
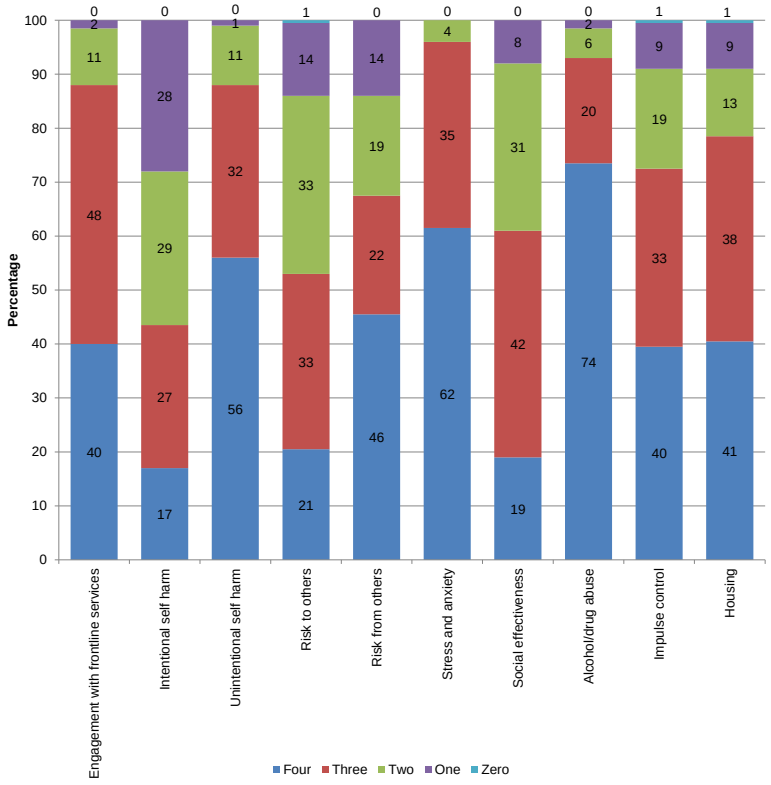


Figure 9: Proportion of service users at each stage of the Chaos Index at baseline assessment; 16 May 2016



Outcome change

This section presents evidence on outcome change to date for service users who had ever been in the navigator caseload and who had completed a follow up Homelessness Outcome Star or Chaos index assessment. However it is important to stress that caution is required when interpreting the change data. It only covers outcome change to 16 May 2016. Different results are likely to emerge as more service users engage with the project over longer time periods. Longer term assessments are likely to reveal the path to independence is nonlinear and includes both forward and backward steps.

Homelessness star

One hundred and three service users who had ever been in the navigator caseload had completed a follow up Homelessness Outcome Star assessment. Figure 10 shows how the average score on each of the 10 areas compare at the baseline assessment to their latest assessment, for all service users who had ever been in the navigator caseload. Positive progression (a shift outwards) has been identified across all 10 areas with average scores increasing by at least 0.2 points on the 10 point scale. The largest absolute increases have been recorded on the 'managing tenancy and accommodation', 'offending', and 'drug and alcohol misuse' and 'motivation and taking responsibility' areas.

Figure 10: Average service user Homelessness Outcome Star scores at their baseline and latest assessment; 16 May 2016

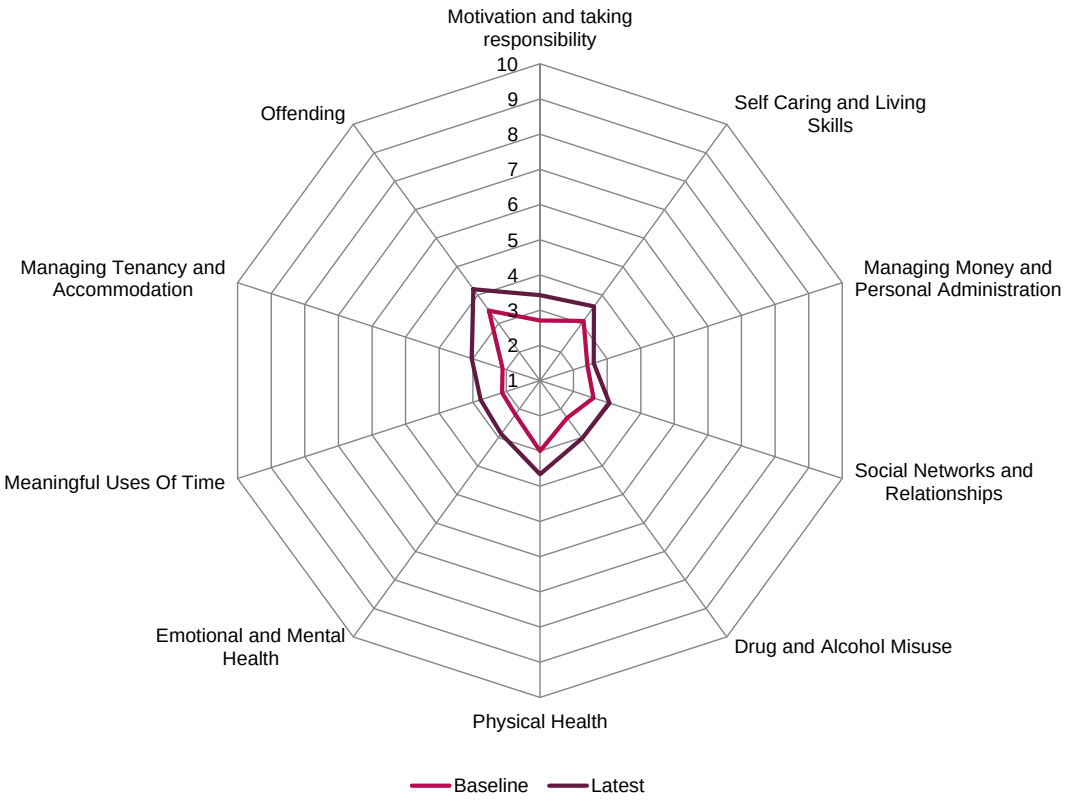
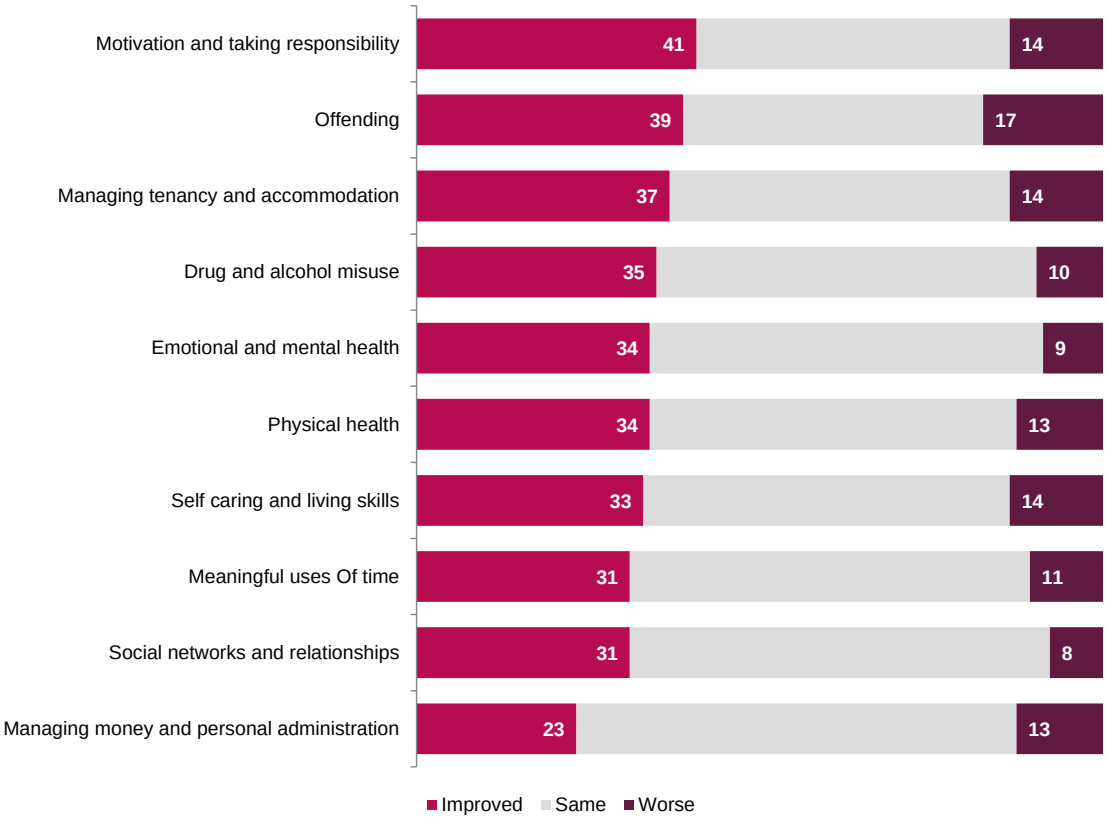


Figure 11 shows on all 10 areas the proportion of service users who reported an improvement was greater than the proportion of service users who reported a worsening. The three areas with the largest proportions of service users reporting an improvement between their baseline and last follow up assessment were:

- motivation and taking responsibility, 41 per cent reported an improvement
- offending, 39 per cent reported an improvement
- managing tenancy and accommodation, 37 per cent reported an improvement.

Figure 11: Percentage of service users with improved and worse Homelessness Outcome Star scores between their baseline and latest assessment; 16 May 2016



There was a reduction in the percentage of service users who had ever been in the navigator caseload who reported being stuck on each of the 10 areas (Table 6). This included the following four areas were over 20 percentage points fewer service users reporting being stuck:

- emotional and mental health
- motivation and taking responsibility
- drug and alcohol misuse
- social networks and relationships.

Table 6: Percentage of service users with a Stuck Homelessness Outcome Star score at their baseline and latest assessment; 16 May 2016

	Baseline	Latest
Motivation and taking responsibility	61	38
Self caring and living skills	50	34
Managing money and personal administration	64	54
Social networks and relationships	63	43
Drug and alcohol misuse	72	50
Physical health	49	31
Emotional and mental health	69	44
Meaningful uses of time	72	53
Managing tenancy and accommodation	68	49
Offending	46	32

Chaos

One hundred and thirteen service users who had ever been in the navigator caseload had completed a follow up Chaos Index assessment. The average service user Chaos Index score reduced from 37.0 to 30.5 between their baseline and latest Chaos Index assessment. Just over three quarters (76 per cent) of service users reported an improvement in their Chaos Index score and only 18 per cent recorded a worsening.

Figure 12 shows how the average score on each of the 10 areas compare at the baseline and last assessment for service users who had ever been in the navigator caseload. In this instance a reduction or inwards shift indicates an improvement. The average score improved on all 10 areas, with 'housing' and 'risk from others' seeing the largest score reductions.

Figure 13 shows on all 10 areas the proportion of service users who reported an improvement was greater than the proportion of service users who reported a worsening. The three areas with the largest proportions of service users reporting an improvement between their baseline and last follow up assessment were:

- housing, 56 per cent reported an improvement
- risk from others, 48 per cent reported an improvement
- engagement with frontline service, 46 per cent reported an improvement.

Figure 12: Average service user Chaos Index scores at their baseline and latest assessment; 16 May 2016

Figure 13: Percentage of service users with improved and worse Chaos Index scores between their baseline and latest assessment; 16 May 2016

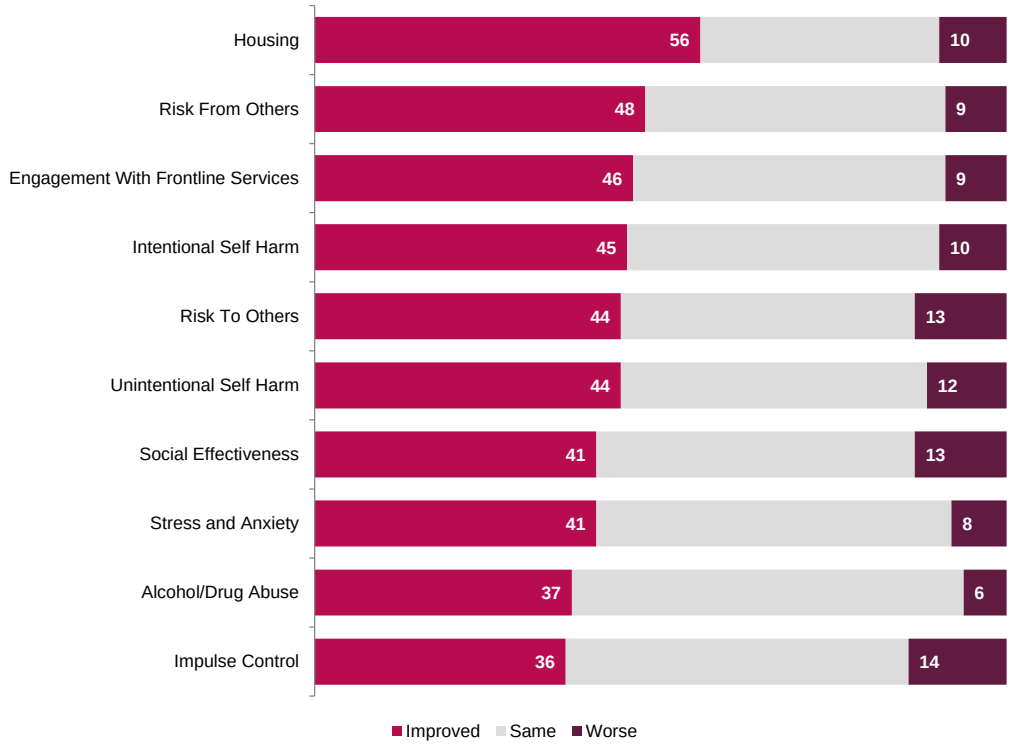


Table 7 shows there was a reduction in the percentage of service users who had ever been in the navigator caseload who reported being in the highest category on each of the 10 areas of the Chaos Index. This included the following five areas were over 20 percentage points fewer service users reporting the highest score:

- risk from others
- alcohol/drug abuse
- unintentional self-harm
- stress and anxiety
- housing.

Table 7: Percentage of service users with the highest Chaos Index score at their baseline and latest assessment; 16 May 2016

	Baseline	Latest
Engagement with frontline services	35	19
Intentional self-harm	19	12
Unintentional self-harm	58	36
Risk to others	22	12
Risk from others	50	25
Stress and anxiety	61	40
Social effectiveness	17	10
Alcohol/drug abuse	76	52
Impulse control	38	27
Housing	42	21

Summary

This chapter has provided a description of activity (outputs) to date, the baseline characteristics of WY-FI service users and evidence on outcome change. Key headlines include:

- WY-FI received notification forms for 817 individuals with presumed multiple and complex needs; of these partners were able to make contact with 446 individuals (55 per cent)
- 308 service user journeys had begun by 14 May 2016, including 200 who had ever been in the navigator caseload. 71 service users were in pre-navigation or case finding
- 69 per cent of service users who had ever been in the navigator caseload had four needs; 26 per cent had three needs
- substance misuse (98 per cent) and mental health (97 per cent) were the most commonly identified needs
- analysis of Homeless Outcome Star and Chaos Index data illustrates the multi-faceted needs of service users and the support required to facilitate the journey towards independence which lies ahead

- analysis of follow up Homeless Outcome Star and Chaos Index assessments reveals service users have made significant progression towards independence; for example:
    - there was a reduction in the percentage of service users who reported being stuck on each of the 10 areas of the Homelessness Outcome Star including four areas were over 20 percentage points fewer service users reporting being stuck
    - average Chaos Index score decreased from 37.0 to 30.5
    - the proportion of service users who reported an improvement on all 10 areas of the Chaos Index was greater than the proportion who reported a worsening.

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