Ministry of Housing, Communities & Local Government

Evaluation of the Changing Futures programme

Third Interim report

October 2024

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Ministry of Housing, Communities and Local Government

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About

The Changing Futures programme is a £77 million initiative between the UK Government and The National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage — including homelessness, drug and alcohol problems, mental ill health, domestic abuse, and contact with the criminal justice system. The programme is running in 15 areas across England, between them covering 34 top-tier council areas, from 2021 to 2025.

The Department for Levelling Up, Housing and Communities (DLUHC) appointed a consortium of organisations, led by CFE Research and including Cordis Bright, Revolving Doors, and the Sheffield Centre for Health and Related Research (SCHARR) at The University of Sheffield, to undertake an independent evaluation of the Changing Futures programme. DLUHC is now called the Ministry of Housing, Communities and Local Government (MHCLG).

This report presents individual, service and system level outcomes achieved after the programme has been running for approximately two years. It particularly focuses on trauma-informed approaches and how areas are joining up support for people — the second of a series of in-depth looks at aspects of systems change that we will cover in these reports.

This report was written by CFE Research with Cordis Bright in November 2023.

For more information on this report please contact cfp@communities.gov.uk.

Foreword

This report presents the latest evidence and insights from the Changing Futures programme, building on the previously published baseline report and second interim report. As a learning programme, Changing Futures aims to understand how improved services and outcomes for adults experiencing multiple disadvantage can be achieved.

The evidence presented in this report combines quantitative outcomes data with insights from qualitative interviews, setting out individual, service and system level outcomes achieved after the programme has been running for approximately two years. The latest round of 'deep dive' qualitative research focused on joining up support around the participant and trauma-informed approaches.

The evidence indicates that participants are making progress to more fulfilled and stable lives. Many of the key individual outcomes' measures are showing small but significant positive changes, including accident and emergency callouts, ambulance attendances, domestic abuse, and rough sleeping.

A trauma-informed approach is helping to build trust and facilitate tailored support for participants. Qualitative research indicates there is progress towards more trauma-informed local systems, although the extent of this progress across the areas is mixed.

There is continued evidence of the effectiveness of the caseworker model and the crucial role it plays in supporting participants, including helping people to access a range of services when they need them. However, there is a lack of evidence as to whether the caseworker role has yet embedded at the system level, or of its sustainability beyond the end of the programme.

Further qualitative fieldwork, statistical analysis of change in outcomes, and an assessment of the programme's value for money will be included in future elements of the programme evaluation.

I would like to once again thank CFE Research and their partners for their hard work on this report, conducting research and synthesising evidence; the evaluation advisory group who have provided their expertise; and colleagues at MHCLG for providing feedback on this report and helping steer the development of research materials.

My huge thanks also go to programme and service staff in Changing Futures areas for their ongoing management of the questionnaire data collections and their engagement with the qualitative research. I am also extremely grateful to the programme beneficiaries who participated in this research for their time and sharing their experiences with us.

Stephen Aldridge
Director for Analysis and Data & Chief Economist
Ministry of Housing, Communities &Local Government

List of acronyms, abbreviations and specialist terms

DLUHC: Department for Levelling Up, Housing and Communities

MHCLG: Ministry of Housing, Communities and Local Government

DWP: Department for Work and Pensions

EDI: Equality, diversity and inclusion

Fulfilling Lives: An eight-year programme funded by The National Lottery Community Fund that supported people experiencing multiple disadvantage

GDPR: General Data Protection Regulation – a European Union regulation on information privacy.

Integrated Care Board (ICB): A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in an ICS area – see below.[1]

Integrated Care System (ICS): A partnership of organisations that come together to plan and deliver joined-up health and care services. Twenty-four ICSs were established across England on a statutory basis on 1 July 2022. The purpose of ICSs is to bring organisations together to improve health outcomes, tackle inequalities, enhance productivity and value for money, and help the NHS to support broader social and economic development.[2]

JSNA: Joint Strategic Needs Assessment – an assessment of the current and future health and social care needs of the local community.

MDT: Multi-disciplinary team

MEAM Approach Network: The Making Every Adult Matter Approach Network has supported partnerships across the country to develop coordinated approaches to tackling multiple disadvantage.

Monkey dust: A synthetic psychoactive drug, the use of which has been particularly problematic in Stoke-on-Trent. See for example: https://www.gov.uk/government/news/government-seeks-advice-on-monkey-dust

NDTA: New Directions Team Assessment — a tool for assessing need and risk across 10 areas, including engagement with services, self-harm, and social effectiveness

ReQoL: Recovering Quality of Life is a patient-reported outcome measure that assesses the quality of life of those with mental health problems.

Trauma-informed practice: Trauma-informed practice is an approach to health and care interventions that is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development.[3]

VCSE: Voluntary, Community and Social Enterprise

Executive Summary

About Changing Futures

The Changing Futures programme is a £77 million initiative of the UK Government and The National Lottery Community Fund that tests innovative approaches to improving outcomes for people experiencing multiple disadvantage. The programme is running in 15 areas, which together cover 34 top-tier council areas across England.

The programme seeks to achieve change at three levels:

- For individuals, improving health, safety, wellbeing, and access to services.
- For services, promoting greater integration and collaboration across local services, alongside increased use of a person-centred, trauma-informed approaches, and in the long-term, reducing demand on services.
- For the wider system of services and support, promoting strong multi-agency partnerships, governance, and better use of data so that local strategy and commissioning better responds to and prevents multiple disadvantage.

This report is the third interim report from the Changing Futures evaluation, and examines individual, service and system level outcomes achieved after the programme has been running for approximately two years. It particularly focuses on trauma-informed approaches and how areas are joining up support for people. This is the second of a series of in-depth looks at how the programme is promoting change at different levels – the previous report explored how areas are seeking to address systems change in relation to commissioning services.

The report draws on quantitative data from participant questionnaires, a survey of local stakeholders in funded areas, and qualitative research with staff, stakeholders and participants from five selected areas. The evaluation adopts a theory-based and largely qualitative approach to explaining outcomes observed during the programme at the individual, service and systems level. Complex systems such as this can be challenging to evaluate and establish causality. The evaluation overall includes the use of a theory of change, systems mapping, participatory approaches, and the triangulation of qualitative and quantitative data to help understand how the different elements of the systems interact and to identify key mechanisms of change. However, it is difficult to establish the extent to which factors external to the programme are also having an effect on outcomes.

Participant outcomes

Up to October 2023, 3,783 people had received direct support from the Changing Futures programme. Most (58.8 per cent) were reported to still be actively engaged. 20.4 per cent had disengaged and a similar proportion had moved on. Of those who had moved on, in the majority of cases (79.6 per cent, n=329) this is because they no longer required support or were receiving appropriate support outside the programme.

Overall, there continues to be evidence of positive changes in people's wellbeing and quality of life. Participant physical health is improving or being maintained for many. Alongside this, there is a significant reduction in average attendances at A&E and ambulance call outs between baseline and the first follow-up point. Participants reported receiving help from Changing Futures to apply for benefits, manage budgets and address debt. Quantitative indicators show increases in people receiving income from benefits and ability to manage debt and overdue bills. Participants also feel more socially connected as a result of being supported to access a wide variety of social and therapeutic activities. As we saw in the previous interim report, there is a reduction in the proportion of people with no-one to talk to (other than their support worker) and an increase in people who say they feel well connected to family members.

Some measures show more change than others. Whilst 1 in 3 participants reported improved mental wellbeing, for the majority there is little change. Similarly, roughly a third of people were more positive about their ability to cope with problems without misusing drugs or alcohol compared to when they joined the programme, this remains problematic for many. Recovery from drug and/or alcohol problems is a long-term endeavour and substantial change within the timeframe of the Changing Futures programme may not be realistic. And whilst there is no significant reduction in the proportion of people with negative interactions with the criminal justice system (arrests, convictions etc.) there are reductions in the proportion of people who have been a victim of both violent and other types of crime and reductions in people who have recently experienced domestic abuse.

While some people have moved from homelessness into more stable forms of accommodation, others have moved in the opposite direction. More positively, there is an overall sustained reduction in rough sleeping between baseline and the second follow-up point (on average, roughly eight months after starting with the programme).

Embedding trauma-informed practice

Trauma-informed practice means realising that trauma can affect individuals, groups and communities; recognising the signs, symptoms and widespread impact of trauma; and preventing re-traumatisation. It can encompass not only how workers interact with people, but also elements such as service environments, policies, and processes.

Changing Futures caseworkers use trauma-informed practice when working with participants. They are enabled by their organisations to do this through supportive working conditions including access to clinical psychologists, reflective practice, flexible working and the provision of training. This has resulted in staff reporting greater job satisfaction compared to previous roles.

There is evidence that this is having a beneficial impact on participants. Trauma-informed approaches, along with small caseload sizes (between 7 and 12), help build trusting relationships and facilitate tailored support. This is leading to better engagement, not just with Changing Futures but with other services. Our analysis shows a link between smaller caseload sizes and improved levels of participant need and risk.

Funded areas are also seeking to improve understanding and adoption of trauma-informed practice in local services. They are doing this by demonstrating the benefits of the approach, providing training and resources and dedicated roles promoting trauma-informed care. Progress is being made, although the evidence on the extent of progress is mixed. There appears to be increased awareness of multiple disadvantage and trauma-informed practice. Most respondents to our survey had received training in trauma-informed working in the past year. And while most respondents also indicated they are delivering key elements of trauma-informed care, interviewees were less confident about the impact of the programme beyond raised awareness.

Joining up support around the service user

There are few significant changes in the overall proportions of people in recent contact with core services (mental health, substance misuse, homelessness, domestic abuse and probation). While some participants have moved to being in contact with services, others have stopped being in contact. While contact does not necessarily equate to receiving treatment or other assistance, we might expect to see more consistent contact with mental health and substance misuse services, given the long-term nature of recovery in these areas. Better access to mental health services is particularly important – our analysis shows that participants with recent contact with mental health services are also more likely to report improved ability to cope with mental health problems and reduced homelessness.

There are, however, increases in the overall proportion of people contacting other types of service (this could include healthcare and welfare rights advice). Participants also receive support on a wide range of activities, such as accessing a GP, maintaining their accommodation and thinking about personal goals. Some types of support appear more important to this cohort than others. The qualitative research shows the importance of support to attend appointments, and the quantitative data shows that those who get this type of help are also more likely to have improved levels of need and risk. The more different types of support people receive the more likely they are to report improved quality of life. The qualitative research emphasises the importance of highly personalised support – what works for one person may not be appropriate for someone else.

Changing Futures caseworkers and multi-disciplinary team meetings are both playing important roles in improving access to and co-ordination of services. Caseworkers act as the ‘glue’ holding diverse services together around the participant. Multi-disciplinary meetings and groups provide a focus for coordinating support at both the operational and strategic levels. Areas are also developing bespoke solutions to local barriers. But the programme is also providing direct support in areas that might normally be considered within other services remit (in particular, providing mental health/wellbeing support and emergency accommodation) where they are unable to secure access to these services otherwise.

Participants and stakeholders reported that caseworkers are helping people to access a range of services when they need them. Caseworkers’ persistent approach has led to participants being more willing to engage with support. There is also evidence of change in some local services with professionals being more flexible and less risk averse when it comes to supporting Changing Futures participants. Services and staff appear to be communicating better and sharing information about service users more frequently.

Professionals (both within and external to Changing Futures teams) appear to have a better understanding of what support is available across the local system and how to access it. Linked to this, there are examples of reducing duplication of effort. However, it is not clear the extent to which these improvements in services are experienced by people who are not being supported by Changing Futures, nor if these improvements will be sustained beyond the lifetime of the programme.

Challenges and enablers

The latest round of qualitative research has identified a number of challenges and enablers in relation to achieving effective delivery and impact. These challenges and enablers relate to both programme design and its wider context and provide useful learning for future work.

Several challenges relate to the time-limited nature of the programme. It takes time to build relationships with participants, therefore imposing time limits on supporting people is likely to be unhelpful. Moreover, this limits what progress might be achieved within the timeframe of the programme. Building understanding of the programme offer locally has also required effort and this has affected the ability of the programme in some areas to make swift progress in joining up support. Those areas with forerunner or parallel programmes of activity (such as Fulfilling Lives and Making Every Adult Matter (MEAM)) have been helped by having a foundation of relationships, understanding and credibility on which the Changing Futures programme has been able to build.

Caseworker flexibility is key to the Changing Futures model, but there are limits to this. There is a need to agree what ‘flexible’ means in practice. Balancing flexibility with managing risk can sometimes be difficult. As the programme has grown, caseworker and other programme staff capacity has become strained in some instances.

There are features of the programme that have assisted with delivery. Alignment of the aims of Changing Futures with other services’ goals has helped to build support. Working within a diverse team of professionals from a range of backgrounds is beneficial for sharing knowledge, in particular on navigating data systems. Embedding the team within a well-connected and credible host organisation can also generate buy-in to the programme. Having supportive senior managers gives caseworkers back-up and can help unblock system problems.

Beyond the Changing Futures teams, contextual issues have presented challenges to the programme. Capacity and staff challenges within core services make it difficult for participants to get the flexible support they want, or any support at times. For similar reasons, it can be difficult to engage some services in training and/or multi-disciplinary meetings. This is particularly the case for statutory mental health and housing/homelessness services.

Despite the positive progress outlined in the previous section, the overall impact of the programme on local services is at this still stage limited: some services remain risk averse and reluctant to support people experiencing multiple disadvantage. People continue to be stigmatized and branded as undeserving or difficult. Further, despite delivering training, staff turnover also makes embedding trauma-informed working more challenging. Despite

this, there is growing interest in and awareness of the importance of trauma-informed working, and the programme has made progress in raising awareness of multiple disadvantage.

1 Introduction and background

1.1 About this report

This is the third interim report from the Changing Futures evaluation. It presents individual, service and system level outcomes achieved after the programme has been running for approximately two years. It focuses in particular on trauma-informed approaches and how areas are joining up support for people. This is the second of a series of in-depth looks at aspects of systems change– the previous interim report explored how areas are seeking to address systems change in relation to commissioning services. This report builds on and updates information provided in the baseline report published in April 2023 and the second interim report published April 2024.[4]

The report draws on evaluation activities and data collection completed up to October 2023. These include:

- analysis of quantitative data on programme delivery and participants (people experiencing multiple disadvantage who are receiving direct support from the programme)
- qualitative research with programme staff, local stakeholders, and participants from five Changing Futures areas, and
- a survey of local stakeholders disseminated by all funded areas (the 'partners survey').

1.2 Programme aims and progress to date

The Changing Futures programme aims to improve outcomes for adults experiencing multiple disadvantage by developing a more joined-up, 'whole person' approach to support. The programme seeks to make an impact at the individual, service and systems levels:

- **Individual level:** stabilised and improved outcomes for local cohorts of adults experiencing multiple disadvantage.
- **Service level:** greater integration and collaboration across local services to provide a person-centred approach, and reduced demand on reactive services.
- **Systems level:** strong multi-agency partnerships, governance, and better use of data, leading to lasting systems change and informing commissioning. Learning from evaluation and partnerships between government and local areas improves cross-government policy.

By ‘system’ we mean the services and support that might be accessed by a person experiencing multiple disadvantage, including how different organisations and people within those organisations interact with one another and with people experiencing multiple disadvantage.

The Ministry of Housing, Communities and Local Government (MHCLG) has developed a theory of change which underpins the programme activity and evaluation. This can be found in the baseline report.

There is local flexibility in how the programme is delivered, but funded areas are expected to work within a set of core principles:

- **Work in partnership** across local services and the voluntary and community sector at a strategic and operational level.
- **Coordinate support** and better integrate local services to enable a ‘whole person’ approach.
- **Create flexibility in how local services respond,** taking a systems-wide view with shared accountability and ownership and a ‘no wrong door’ approach to support.
- **Involve people with lived experience** of multiple disadvantage in the design, delivery and evaluation of improved services and in governance and decision making.
- **Take a trauma-informed approach** across the local system, services and in the governance of the programme.
- **Commit to driving lasting systems change,** with long-term sustainable changes to benefit people experiencing multiple disadvantage and a commitment to sustaining the benefits of the programme beyond the lifetime of the funding.

The 15 areas to receive funding were announced in July 2021. The first people to receive direct support from the programme joined in September 2021, and all areas had recruited at least some participants by July 2022. As well as providing direct support to people experiencing multiple disadvantage, activities funded by the programme include:

- **Strategic collaboration**, such as investment in partnership infrastructure and joint commissioning.
- **Lived experience** involvement, such as peer researchers and structures for involving people in governance.
- **Workforce development** and training in, for example, trauma-informed practice.

- Case management and **data systems** to improve joint working across local agencies and improve the use of data.

Further details on the 15 funded areas and their approaches can be found in the baseline report.

The Changing Futures programme and evaluation were preceded by Fulfilling Lives — an eight-year programme funded by The National Lottery Community Fund to better support people experiencing multiple disadvantage.[5] The programme ran in 12 areas of England, some of which have gone on to become or be incorporated into Changing Futures areas. Since 2013, the Making Every Adult Matter (MEAM) Approach Network[6] has supported partnerships across the country to develop effective, coordinated approaches to tackling multiple disadvantage. Evaluations of both Fulfilling Lives and the MEAM Approach have provided a significant evidence base on multiple disadvantage and we have supplemented findings from the Changing Futures evaluation with insights from these evaluations.

Programme participants to date

Up to October 2023, 3,783 people had received direct support from the Changing Futures programme. By August 2023 the evaluation team had received data on 2,433 of these – an increase of nearly 900 since the previous interim report. Table 1.1 below shows how these numbers break down by area. A high level of variation in the number of participants is expected across funded areas because each has differing scales of funding and delivery plans.

In August 2023, 58.8 per cent of participants (n=1,756*, see Table A2.1) were reported to be actively engaged in the programme. 20.4 had disengaged and a similar proportion had moved on. Of those who had moved on, in the majority of cases (79.6 per cent, n=329, see Table A2.2) this is because they no longer required support or were receiving appropriate support outside the programme. Of those who had disengaged, in most cases this was because they could not be reached (55.9 per cent, n=349, see Table A2.3). 16 per cent had disengaged due to interaction with the criminal justice system, for example, because of a long custodial sentence. 25 participants (7.2 per cent) had died.

Those who have disengaged (for whatever reason) spent an average of just over five months on the programme, although length of time ranges from a matter of days to almost two years.

* Engagement status data is missing for 677 participants with a programme start date.

Table 1.1: Total programme participants by area.

Area	Total participants in evaluation dataset – August 2023	Total participants reported to DLUHC – October 2023
Bristol	57	66
Essex	148	155
Greater Manchester	342	415
Hull	60	91
Lancashire	637	1,109
Leicester	99	120
Northumbria	24	30
Nottingham	141	198
Plymouth†	-	202
Sheffield	89	84
South Tees	448	574
Stoke-on-Trent	88	335
Surrey	83	90
Sussex	136	214
Westminster	77	142
Total	**2,433**	**3,783**

Numbers include active participants and those who have left the programme. The first column shows participants appearing in the evaluation dataset and the second shows total programme participants.

1.3 Evaluation objectives

MHCLG has set three objectives for the evaluation, namely to:

- Provide evidence on whether (and why/how) Changing Futures has made a difference to **individuals** who experience multiple disadvantage.

- Provide evidence on whether (and why/how) Changing Futures has made a difference to how **public service systems** operate, including considering how systems-level

† Plymouth is focusing on systems-level change, rather than a new client-facing service. As a result, they are not providing individual-participant-level data to the evaluation team.

changes affect the way in which services operate and are delivered and experienced by people who experience multiple disadvantage.

- Assess the **value for money** of the programme and make recommendations as to the most effective use of any additional resources going into this area in the future.

Chapter 2 of this report focuses on changes for individuals experiencing multiple disadvantage. Chapter 3 examines how and to what extent trauma-informed practice has been embedded in the way public services work in funded areas. Chapter 4 brings the individual and systems levels together to explore the support services participants are using and how funded areas are working to join up services and improve access.

In order to test, refine and develop the programme theory of change, we have developed an evaluation framework detailing how progress towards the short- and longer-term outcomes will be measured. As well as providing evidence of programme achievements, progress towards these outcomes will be used to learn about and reflect on the implementation of the programme. A summary of the framework can be found in the baseline report.

1.4 Methods, data sources and limitations

The evaluation considers a complex range of interventions being delivered in a changing context. As set out in the Treasury's supplementary guidance on the topic, complex systems can be challenging to evaluate. Not only is proving causality difficult, but complex systems can also be particularly sensitive to context and vulnerable to disruption.[7] As a result, our evaluation adopts a theory-based approach to explaining outcomes observed during the programme. We use a mixed-methods approach, combining qualitative and quantitative data from a range of sources. The findings in this report draw on quantitative data on participants, qualitative research with a sample of funded areas, and a survey of stakeholders.

This is an interim report. Data collection and other evaluation activities are ongoing and further evidence of change will be gathered for inclusion in future reports.

Further detail on the evaluation methods and data sources can be found in Appendix 1.

Quantitative data and analysis

Quantitative data collected by funded areas comprises:

- details of participants' engagement status and dates, referrals to other services and outcomes (service-held outcomes data)

- repeated questionnaires conducted with participants (outcomes questionnaires)

- a separate questionnaire on participants' characteristics and experiences of disadvantage (historical questionnaire)

- regular assessments of participants' levels of need and risk (New Directions Team Assessment or NDTA), and

- operational data on caseload sizes, staff teams etc.

These data are submitted to the evaluation team on a quarterly basis.

Longitudinal analysis has been carried out on participant-reported outcomes (outcomes questionnaires) as well as staff assessments of need and risk (NDTA). Multivariate regression was used to explore the associates of change in ten key outcomes. Regression analysis in this context provides a useful tool to identify the individual characteristics and contact with support services that are associated with outcomes. The regression models should not be used as evidence of a causal relationship or of the direction of influence. We report results that are significant at the five per cent level.

Most analysis in this report roughly covers participants' first six months on the programme. As participants join the programme on a rolling basis, these six months are not the same six months for all participants and span the period from September 2021 to August 2023. Furthermore, some participants will have received several months of support before providing baseline data and so not all change is captured.

Factual questions in the outcomes and historical questionnaires can be populated using staff knowledge to reduce the need for people to repeat their stories multiple times. Not all participants have data for all four of the sources or all questions. As a result, base sizes vary throughout this report depending on the indicator. Base sizes decrease for longitudinal analysis. This is because we require valid responses to both baseline and follow-up questionnaires. We have a total of 1,569 baseline questionnaires, but only 751 first follow-up questionnaires and 350 second follow-up questionnaires. Attrition of sample size over time is to be expected, particularly given the target cohort, but we will continue to accumulate more longitudinal data as the programme progresses.

Partners survey

The Partners survey seeks to capture information from stakeholders in Changing Futures areas to understand the extent to which local service- and systems-level outcomes are achieved over the programme's lifetime. The survey was carried out online between September and October 2023. This was a follow-up to a baseline survey undertaken between August and September 2022 – see baseline report for further details.

In total, 491 useable survey responses were received – a similar number of responses to the baseline survey. While the response rate to the follow-up survey is more evenly distributed across the 15 Changing Futures areas than the baseline survey, some areas

still achieved a very low response rate (see Table A1.3). The change in distribution of responses across areas also indicates that in many cases the respondents are different from the baseline survey. As a result, the follow-up survey results should not be *directly* compared with the baseline survey results, although baseline survey results are provided for context.

Qualitative research

In order to explore topics in depth in the qualitative research, each round of fieldwork focuses on selected 'deep dive' themes. This latest round of fieldwork focused on joining up support around the participant and trauma-informed approaches.

In-depth qualitative interviews were held with staff, stakeholders and participants in five Changing Futures areas: Bristol, Northumbria, South Tees, Stoke-on-Trent and Surrey. These areas were purposively sampled based on their progress in relation to the topics of interest and may not be representative of all Changing Futures areas. Participants and stakeholders were identified and introduced to us by staff at the funded areas based on who might be most able to comment on the topics of interest. There is a risk, therefore, that the sample might over-represent positive views about the programme.

The qualitative research was supported by a team of 15 peer researchers. Interviews were audio-recorded with interviewees' permission and transcribed in full. The interview transcripts were analysed using thematic analysis.

2 Participant outcomes

This chapter sets out the evidence to date on the achievement of key outcomes at the individual level. Findings are grouped by broad theme. The chapter begins by exploring changes in health, safety and wellbeing, including mental wellbeing. We then go on to look at changes in housing, financial stability and connectedness. Findings are mainly drawn from analysis of the outcomes questionnaires and NDTAs. Data on participant characteristics comes mainly from the historical questionnaire. The quantitative analysis roughly covers participants' first six months on the programme. Some participants will have received several months of support before providing baseline data and so not all change is captured. Quantitative data analysis is supplemented by qualitative insights from participant, staff and stakeholder interviews.

2.1 Health, safety and wellbeing

Key points

- Participants frequently reported in interview that the programme has helped to improve their mental health. 40 per cent of participants reported improved quality of life (as measured by the ReQoL) between baseline and second follow-up.
- There is evidence that the physical health of some participants is improving. The proportion of people who reported no or only slight health conditions increased from 42.7 per cent at baseline to 50.4 per cent at second follow-up.
- Participants said the programme is helping them to access healthcare and there were significant reductions in average attendances at A&E and in ambulance callouts between baseline and first follow-up. The proportion of people with no visits to A&E in the previous three months increased from 62 to 69 per cent between baseline and first follow-up.
- Roughly a third of people (32 per cent) were more positive about their ability to cope with problems without misusing drugs or alcohol at first follow-up compared to baseline. However, 40 per cent indicated they could not cope at both baseline and first follow-up and 17 per cent said their ability to cope had worsened.
- There were no significant changes in the proportion of people who said they had experienced specific negative interactions with the criminal justice system (such as arrests, time in prison etc.) between baseline and first follow-up. The proportion of people who reported being a recent victim of violent crimes reduced between baseline and first follow-up from 43.7 to 34.4 per cent. The proportion of people who reported being a victim of other crimes also reduced over the same period from 37.9 to 27.7.

- There was a reduction in the proportion of people who said they had experienced recent domestic abuse between baseline and first follow-up from 24 per cent to 19.3 per cent. Those aged over 30 were less likely than younger participants to experience such a reduction.

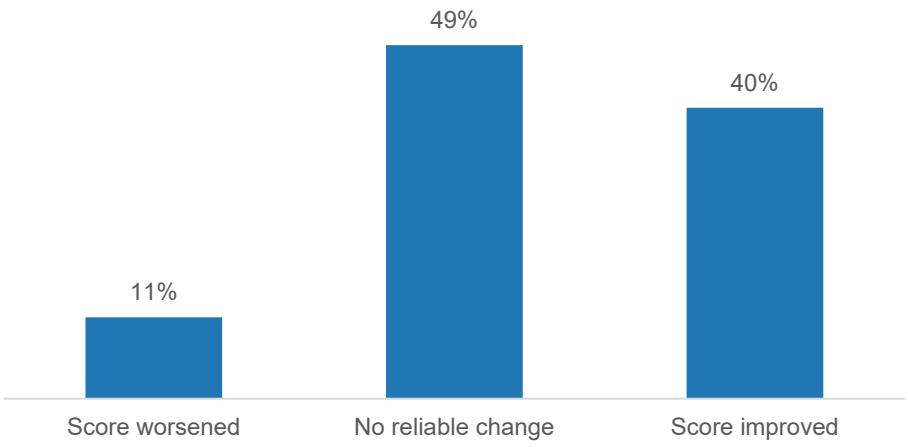
Mental wellbeing

A key outcome measure we use to determine change in mental wellbeing and quality of life is the Recovering Quality of Life or ReQoL measure. This is a patient-reported measure developed to assess the quality of life of people with different mental health conditions. It encompasses 10 different domains of mental health. The minimum score of 0 indicates poorest quality of life and the maximum of 40, indicates the highest quality of life. The smallest change in score that is considered to be reliable and clinically or practically important is five points.[8]

Between baseline and first follow-up, just over a third of participants (36.3 per cent) reported a clinically important increase in their quality of life. Relatively few (10 per cent) reported a worsening score of five points or more (see Table A2.6).

By the second follow-up questionnaire 40.1 per cent reported a clinically important improvement in quality of life. Again, just over a tenth (11 per cent) reported worsening quality of life. (See Figure 2.1 and Table A2.7.)

Figure 2.1: Proportion of participants reporting clinically important change in ReQoL score between baseline and second follow-up (n=232)



Sampled participants commented in interview that the programme has improved their quality of life. Multiple participants reported that they are in a better place as a result

of the support they have received and “further along on the journey to recovery”. Participants appreciate the person-centred and tailored support provided from caseworkers and emphasised the value of having someone who listens to what they have to say and cares about their wellbeing. Additionally, a number of participants commented on the positive impact that activities undertaken with their caseworker, such as going out for meals and daytrips, has on them.

I feel much better. I’m in a much better place. In the past I didn’t have any time or patience, and I previously came across as intimidating. Now I don’t. I had given up hope.

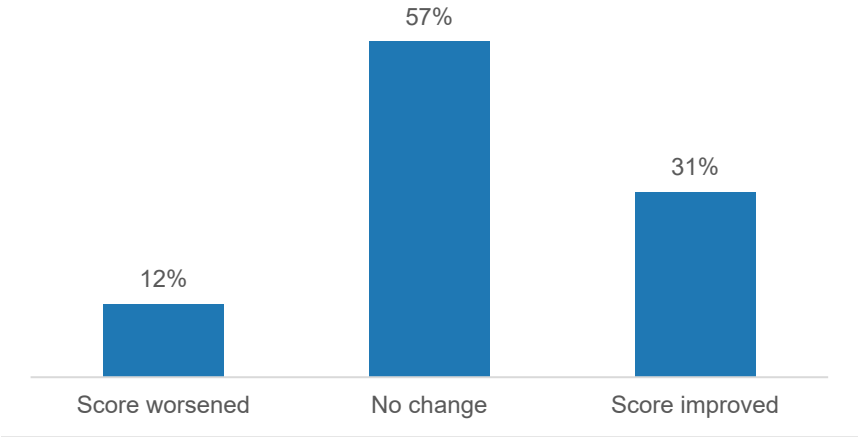
Programme participant

The New Directions Team Assessment[9] (or NDTA) assesses participant need and risk across ten items and provides a composite indication of progress on key outcomes. Each item is rated on a five-point scale, with 0 being the lowest and 4 the highest score. Two items (risk to others and risk from others) are double-weighted. Thus, a reduction in the NDTA score is positive.

Unlike the ReQoL, there is no independent evidence or guidance on what constitutes a meaningful change in NDTA score. For the purposes of the analysis below, we defined a decrease of seven points or more as an improvement and an increase of seven points or more as a worsening of levels of need and risk. The same thresholds were used in the evaluation of the Fulfilling Lives programme.[10]

The majority of participants had no change in NDTA score both between baseline and first follow-up and between baseline and second follow-up. Between baseline and first follow-up, 26.9 per cent of participants received an improved score, while just 5.9 per cent had a worsening in score (see Table A2.10). Between baseline and second follow-up 31.2 per cent of participants received an improved score and 12.3 per cent a worse score (see Figure 2.2 and Table A2.11).

Figure 2.2: Proportion of participants reporting a change in total NDTA score between baseline and second follow-up (n=138)



Among those who experienced an improvement in NDTA score between baseline and first follow-up, just over half also experienced an improvement in ReQoL score over the same time period, with most of the rest experiencing no change in ReQoL. Most people with data for both measures experienced no meaningful change in either (see Table A2.11). We will explore associations between different outcomes in more detail in our next report.

Only caseload size showed a significant association with change in NDTA score in our regression model – this is discussed in more detail in Chapter 4 (see page 34), including the reasons why a low caseload size is of crucial importance when providing intensive casework support to people with experience of multiple disadvantage.

We highlighted in our baseline report that participants generally have high levels of anxiety. **Between baseline and second follow-up, just over half of participants reported a reduction in levels of anxiety** (53.2 per cent, n=248). **However, nearly a quarter (22.6 per cent) reported worse levels of anxiety** (see Table A2.14). Related to this, interviewees reported that participants feel more confident. For example, one participant reported that they have started to feel comfortable enough to step outside of their home for the first time in years. Another highlighted how their caseworker is supporting them to feel more positive.

The other day we went to a charity shop. Before my stroke I could play guitar. I started playing it terribly and later on that day, started talking about it and I was discouraging myself. But my caseworker was there to support me and help build my confidence.

Programme participant

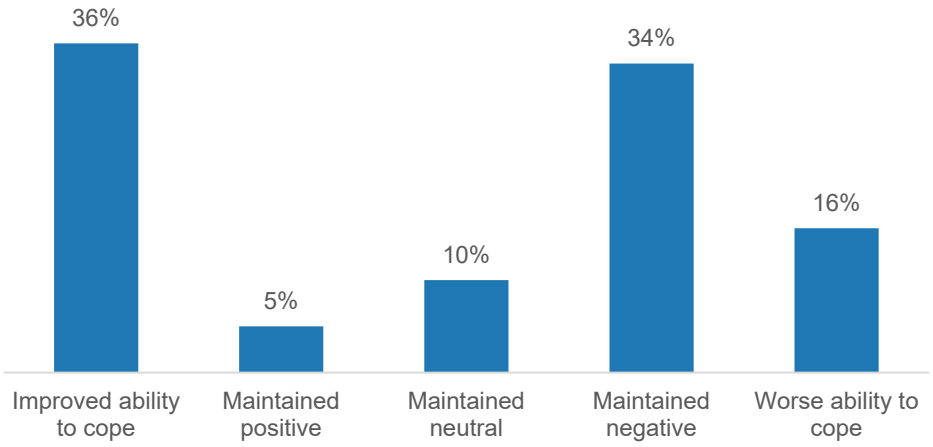
Participants frequently reported in interview that their mental health has improved as a result of the support they have received through the programme. This has been facilitated by a range of activities, particularly caseworkers providing a 'listening ear' and emotional support, as well as support to access appropriate mental health services.

I've got better mental health as a result of the programme. Things are good.

Programme participant

35.7 per cent of respondents reported improved ability to manage their mental health difficulties between baseline and first follow-up. However, a similar proportion (34 per cent) continued to indicate they were unable to manage their difficulties. 16 per cent reported a worse ability to cope. (see Figure 2.3 and Table A2.16).

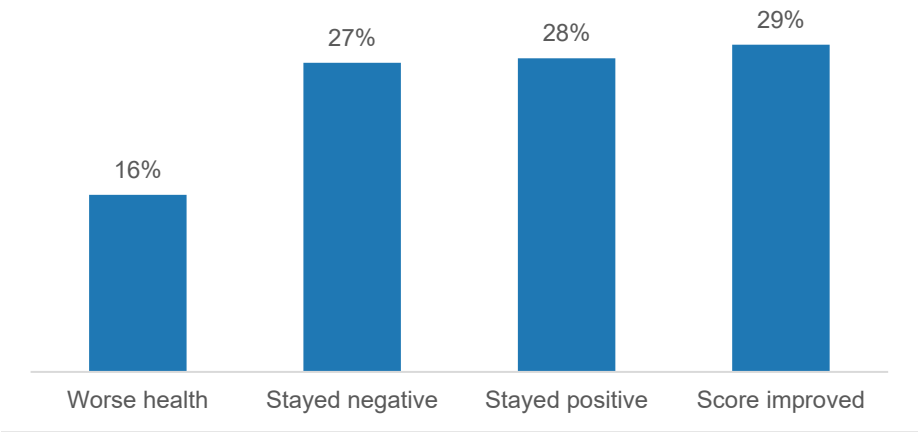
Figure 2.3: Change in response to 'Thinking about the past three months, how much would you agree or disagree with this statement: I am able to effectively manage my mental health difficulties' between baseline and first follow-up (n=319)



Physical health

There is **evidence that the physical health of some participants is improving**. Of people with data at both time points, 42.7 per cent said they had no or only slight physical health problems at baseline; this increased to 50.4 per cent at second follow-up (n=248, see Table A2.17). 29 per cent of people gave a more positive response to the follow-up question and a further 27.8 people had a positive response at both baseline and follow-up. 15.7 per cent of people reported worse physical health at second follow-up compared to baseline (see Figure 3 and Table A2.18).

Figure 2.4: Change in response to the question 'Please describe your physical health over the last week' between baseline and second follow-up (n=248)



Several participants shared in interview that their access to health services such as the GP and the dentist has improved, and that as a result their physical health has improved. Caseworkers have also been able to help participants with basic needs, such as ensuring they have enough food and are taking care of themselves.

Sometimes my hygiene isn't always that good. [My caseworker] pushes me to get on top of it. Helps me with food.

Programme participant

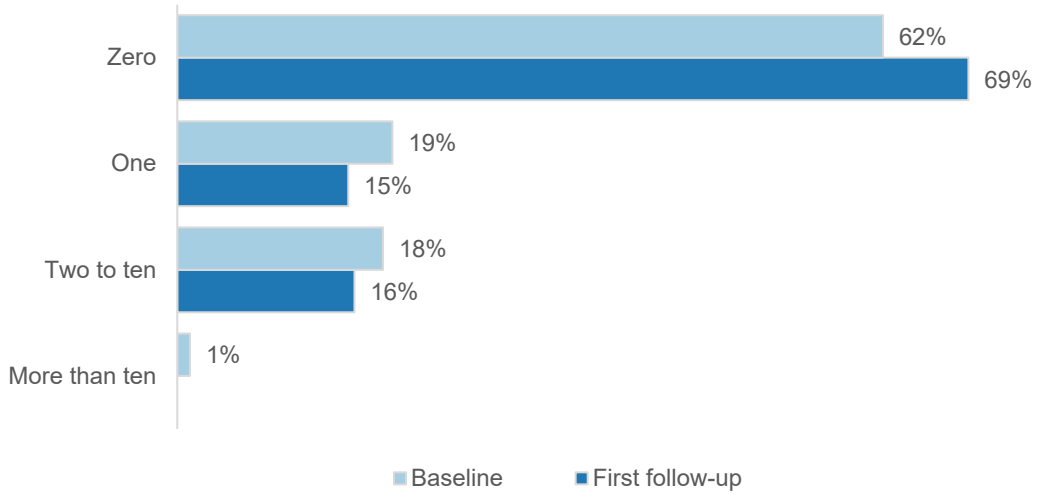
As participants are being supported to access primary health services and receiving bespoke support from caseworkers to address needs, stakeholders indicated that the programme has helped reduce inappropriate use of emergency services, particularly A&E.

I'm the number one presenter at two hospitals due to the experiences I've had. I'm completely different now. Over the last four months, I've not been to hospital.

Programme participant

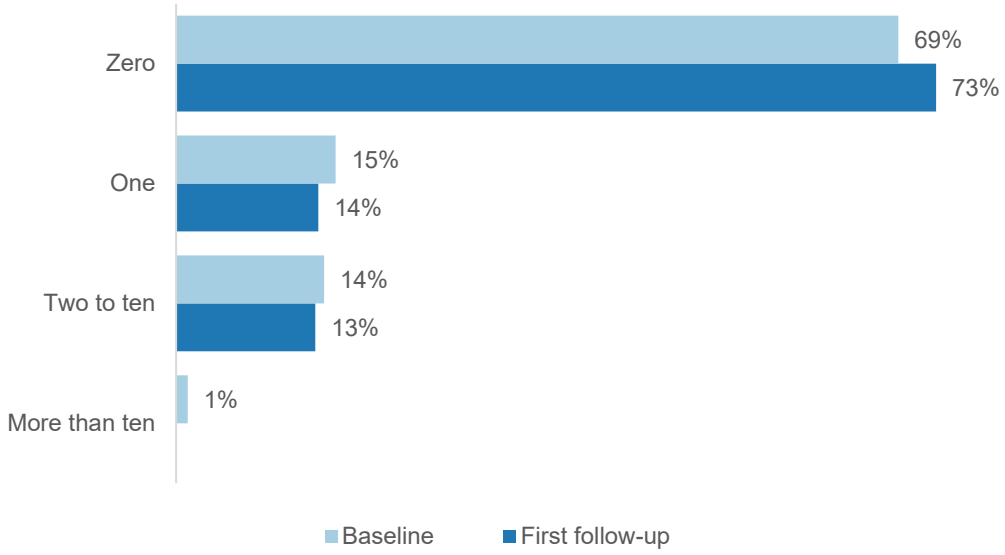
This is reflected in the quantitative data, where **there is a significant reduction in the average number of times participants reported attending A&E in the past three months between baseline and first follow-up** (see Table A2.19). More people are not attending at all by first follow-up (see Figure 2.5) and the maximum number of attendances also dropped, from 45 to 8.

Figure 2.5: How many times in the last three months have you been to the A&E Department, if at all? Comparison of baseline and first follow-up (n=360)



The number of ambulance call outs has reduced too. While 69.4 per cent of people had no ambulance call outs in the previous three months at baseline, this increases to 73 per cent at first follow-up (see Table A2.21 and Figure 2.65)

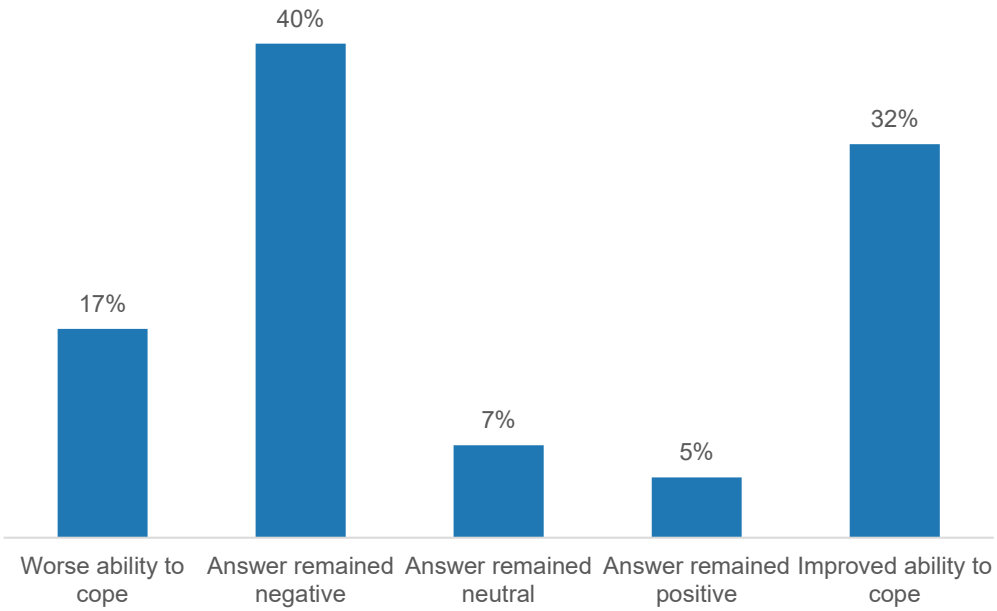
Figure 2.6: How many times in the last three months has an ambulance been called to assist you, if at all? Comparison of baseline and first follow-up (n=359)



Use of drugs and/or alcohol

Roughly a third of people (32 per cent) were more positive about their ability to cope with problems without misusing drugs or alcohol at first follow-up compared to baseline. However, 40 per cent indicated they could not cope at both baseline and first follow-up and 17 per cent said their ability to cope had worsened (see Table A2.24 and Figure 2.76). A similar pattern of change is seen when comparing baseline and second follow-up (see Table A2.25). International evidence highlights the long-term nature of recovery from drug and/or alcohol problems; between 40 and 60 per cent of people relapse within a year of treatment, and five years after treatment 50 per cent of people still meet the criteria for substance use disorder.[11] Progress on this outcome is therefore expected to be limited within the timeframe of the Changing Futures programme.

Figure 2.7: Change in response to 'Thinking about the past three months, how much would you agree or disagree with this statement: I have coped without misusing drugs or alcohol?' between baseline and first follow-up (n=311)



The participant interviews and open feedback in the questionnaires provided examples of people both managing to reduce their drug and/or alcohol use and finding ways to monitor and regulate their use. In some cases, participants are said to have completely stopped using substances. However, the research findings highlight that improvement in this area is challenging and takes time. Many interviewees explained that they had relapsed during difficult periods. However, the programme continued to support their recovery.

[My caseworker has] been there and helped [me] to spend time away from drugs and drug addicts and stopping me from taking it.

Programme participant

Experience of the criminal justice system

There are no significant changes in the proportion of people who say they have experienced specific negative interactions with the criminal justice system (such as arrests, time in prison etc.) between baseline and first follow-up (see Table A2.27). Between baseline and second follow-up the picture is less positive. While no one type of interaction changes significantly, there is a significant reduction in the proportion of people who say they have had none of the listed interactions, from 64.4 to 56.9 per cent (n=202, Table A2.28). This appears to be mainly driven by a small increase in people spending time in prison. Due to the time it takes for offences to be processed through the criminal justice system, this change may not be the result of offending happening while participants were receiving support form Changing Futures.

The regression analysis shows participants in the two older age categories (30 to 49, and 50 plus) are less likely to experience a reduction in negative interactions with the criminal justice system (see Table A2.29).

Stakeholders interviewed from across areas reported that they identify and provide support for people when they leave custody and/or prison. For example, in one area there is a criminal justice case coordinator. Their role is to identify repeat offenders and coordinate support and care to break the cycle of reoffending. They provide participants with a range of support that aids the desistance process, particularly suitable accommodation. However, few participants commented on their experience of the criminal justice system in interviews.

There is a statistically significant reduction in the proportion of people who say they have been a victim of violent crime in the last three months between baseline and first follow-up – down from 43.7 per cent to 34.4 per cent (n=439, see Table A2.30). 67 participants who said they had been a victim in the baseline survey said they had not in the follow-up questionnaire. Similarly, **the proportion of people who said they had recently been a victim of other types of crime reduced** from 37.9 per cent at baseline to 27.7 per cent at first follow-up (n=440, see Table A2.31).

Experience of domestic abuse

There is a small but significant reduction in the proportion of people who say they have experienced domestic abuse in the previous three months between baseline and the first follow-up, from 24 per cent to 19.3 per cent (n=450, see Table A2.32). A similar scale of reduction is seen if we compare baseline with the second follow-up, but

this is no longer significant, likely due to a much smaller sample size (n=248, see Table A2.33).

As well as being more likely to experience domestic abuse generally, women were also more likely to experience a reduction in their experience of domestic abuse between baseline and first follow-up. However, **participants aged over 30 were less likely to experience a reduction in domestic abuse compared to younger participants** (Table A2.36). In contrast, among those who have not experienced domestic abuse recently or felt there was a low risk of a recurrence of domestic abuse, those aged over 30 were more likely to report an improvement in how safe they felt where they lived (Table A2.37).

2.2 Housing, financial stability and social connectedness

Key points

- There was a small but significant reduction in the proportion of people experiencing homelessness between baseline and first follow-up, from 64.1 per cent to 57.3 per cent. However, this was not the case when baseline and second follow-up were compared. Movement of people from homelessness to more stable accommodation is offset by people becoming homeless.
- There was a sustained overall reduction in rough sleeping between baseline and second follow-up from 30.8 to 21.1 per cent.
- Those aged over 50 were less likely to experience reduced rough sleeping than younger participants. Those with any experience of drug and alcohol use were less likely to report increased confidence that they will be in stable housing within the next six months compared to other participants.
- Participant interviewees highlighted how the programme has helped them to access accommodation.
- Participants reported receiving help from Changing Futures to access benefits, manage budgets and address debt. The proportion of people who can manage paying debts increased from 24 per cent at baseline to 36 per cent at first follow-up.
- Participants feel more socially connected as a result of being supported to access a wide variety of social and therapeutic activities. The proportion of people who reported they feel connected to their family increased from 56.3 to 61.2 per cent between baseline and first follow-up.
- There was a reduction in the proportion of people with no-one to talk to (other than their support worker), from 17.4 per cent to 10.6 per cent at second follow-up.

Housing

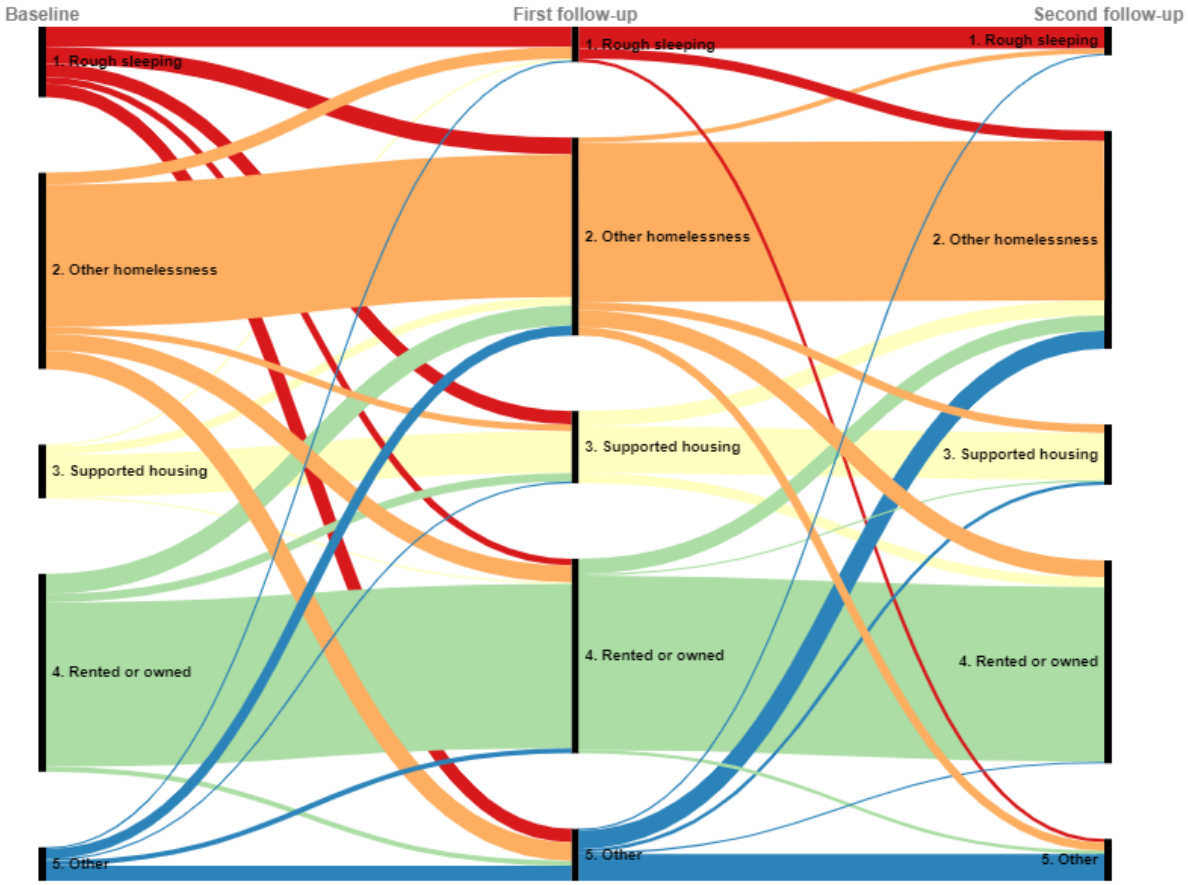
As in our previous interim report, we see **a small but significant reduction in the proportion of people reporting recent experience of homelessness‡**, from 64.1 per cent at baseline to 57.3 per cent at first follow-up (n=562, see Table A2.38). 61 people moved from being homeless to staying in more stable accommodation, however 23 people reported being recently homeless in the first follow-up questionnaire who had not been homeless at baseline. **Comparing baseline and the second follow-up questionnaire (n=292, see Table A2.39) we see no significant change in the overall proportion of people reporting recent homelessness**. While 35 people moved into more stable accommodation, a similar number (27) moved into homelessness. Interviews with stakeholders put these figures into context; many reported that a shortage of suitable, affordable housing and the need for participants to have a local connection to qualify for housing support from a council are barriers to getting people into stable accommodation.

There are, however, significant reductions in the proportion of people who have spent time rough sleeping in the previous three months between baseline and first follow-up and, between baseline and second follow-up. **Almost a third of participants reported some recent experience of rough sleeping in their baseline questionnaire (30.8 per cent). This reduced to almost a fifth by second follow-up** (21.1 per cent, n=299, see Tables A2.40 and A2.41).

Figure 2.8 illustrates the flow of participants between different accommodation types between baseline, first and second follow-up. This shows reductions in rough sleeping resulting from people moving into other forms of homelessness (such as sofa-surfing or hostel accommodation), supported accommodation or other accommodation (including hospital and prison). While some people move from other types of homelessness into rough sleeping, there is no-one in this sample who moves from more stable forms of accommodation, such as supported accommodation or their own tenancy, back into rough sleeping. However, it does show that people in more stable accommodation can slip back into other forms of homelessness.

‡ Homelessness includes rough sleeping (including on transport), staying temporarily at a friend's or family's house (sofa surfing) and staying in a short-term hostel, refuge, or other temporary accommodation such as a B&B or night shelter.

Figure 2.8: 'Where have you stayed most of the time for the last month?' Flow of participants between baseline, first and second follow-up (n=329)



The regression clearly shows that **those who are aged over 50 are less likely to move away from rough sleeping between baseline and first follow-up than younger participants** (see Table A2.42). We found no significant associations between participant characteristics and changes in experience of homelessness (see Table A2.43), but there were associations with contact with core services – see page 41 for further details.

Of those not in stable accommodation, 30 per cent felt confident they would be in stable accommodation in six months' time. This increases to 37.7 per cent by first follow-up (see Table A2.44). The regression also shows that **those with any experience of drug and alcohol use are less likely to experience increased confidence that they would be in stable housing within the next six months between baseline and first follow-up compared to other participants** (see Table A2.45).

Stakeholders described how the programme is supporting participants who are at risk of homelessness or are currently homeless. Across areas, caseworkers are liaising with the local council housing teams and housing providers to improve access to accommodation. In some areas, the programme has provided immediate support for participants who have

become homeless and have not been housed by statutory services, by funding and providing a hotel room where this was not provided by the local authority.

A large proportion of participants taking part in interviews reported that the programme has supported them with their accommodation. Participants who were homeless when they first accessed the programme have been supported into accommodation, including long-term accommodation. Others have been helped into temporary accommodation, such as hostels, and are still receiving support through the programme to access more stable accommodation. Feedback in the questionnaires highlights how addressing housing can allow people to manage other aspects of their life better.

The council were not going to house me, [and Changing Futures] had to sign a contract to get me housed. I got a flat and had to prove I could live there for about a year. It was hard to start with but as a result of the support I've received [from Changing Futures], I've now got my own bungalow.

Programme participant

Financial stability

Several participants who were interviewed had received help to access financial support and the benefits they are entitled to. Support provided includes giving information to participants about what financial support is available, completing forms, liaising with services, and transporting participants to appointments.

The is an **increase in the proportion of participants whose main income is Universal Credit or other benefits** (see Table A2.46). The increase in people claiming other benefits persists to the second follow-up (increasing from 38.4 to 49.8 per cent, n=349). There is also a reduction in the proportion of people whose main income comes from begging between baseline and second follow-up (from 8.3 to 4.9 per cent, n=349, see Table A2.47).

At baseline, 24 per cent of participants agreed they could manage paying off debts. At second follow up, this increased to 36 per cent (see Table A2.48). In interview and in open responses in the questionnaire, participants reported that they have received support to better manage their money and pay off debts. Primarily, this was through caseworkers who have spent time guiding people on how to budget, as well as supporting participants to access and engage with related services such as the Department for Work and Pensions (DWP) and Citizens Advice.

There is someone here to help with budgeting and [my caseworker] has helped with debt.

Programme participant

Connectedness

Participants reported feeling more socially connected as a result of the support they received through the programme, including help to access activities and groups. A number of participants said that they have developed positive connections through services like Alcoholics Anonymous, who also support them on their journey to recovery. Some participants highlighted in in their questionnaire responses how changes to one area of their life can have a knock-on effect on their ability to engage in social interaction. For example, one person reported that receiving financial support through a debt management service had not only helped them deal with debt but had also made them more confident to visit drop-in centres and to make new friends. Several also highlighted volunteering activities they were taking part in, such as helping out at churches, food banks and litter picking within their rehab centre.

I am really enjoying being in my community now - I wasn't a few months ago

Changing Futures participant

There is a significant reduction in the proportion of people who say they have no-one to talk to other than their support worker from 17.2 per cent at baseline to 10.4 per cent at first follow-up (n=395, see Table A2.49). A similar level of change is observed between baseline and second follow-up, from 17.6 to 10.6 per cent (see Table A2.50). There is also **a significant increase in the proportion of participants who say they feel connected to family members**, from 56.3 per cent at baseline to 61.2 per cent at first follow-up (n=366, see Table A2.51).

3 Embedding trauma-informed practice

One of the intended outcomes of the Changing Futures programme at the service level is that all staff deliver trauma-informed care and support. In this chapter we focus on the extent to which trauma-informed practice is spreading and becoming a routine part of support across services in Changing Futures areas. The chapter begins by setting out what we mean by trauma-informed practice and briefly summarises the state of play in funded areas at the start of the programme. It then goes on to describe how Changing Futures teams are taking a trauma-informed approach in supporting participants and how they are working to enable and encourage other services to become more trauma-informed too. Caseworkers are at risk of experiencing second-hand trauma, and so we consider how the programme is supporting its staff. We conclude the chapter by assessing the impact of these activities – on programme participants, the local workforce and the wider system. The chapter draws on evidence gathered through interviews with staff, stakeholders and participants, the second partners survey and operational data on average caseload sizes.

3.1 Background and context

Key points

- Trauma-informed practice means realising that trauma can affect individuals, groups and communities; recognising the signs, symptoms and widespread impact of trauma; and preventing re-traumatisation.
- Before the Changing Futures programme, there was increasing recognition of and movement towards trauma-informed practice.
- However, there are challenges, including services carrying high caseloads, staff not always feeling supported or having the appropriate skills for their role, and inconsistent adoption of trauma-informed practice. Sampled Changing Futures areas are seeking to address these particular barriers.

Defining trauma-informed practice

Trauma-informed practice is a means to reduce the negative impact of traumatic experiences and support positive mental and physical health outcomes. A recent qualitative study concluded that implementation across the UK to date has been variable, with a nation-wide strategy and leadership visible in Scotland and Wales but more disjointed implementation in England.[12]

Research suggests that 85 per cent of people facing multiple disadvantage as adults experienced trauma earlier in their lives.[13] It is therefore vital that services to support them take account of this and respond accordingly so that people are able to engage and have positive experiences. As set out in our baseline report,[14] a lack of understanding of the way trauma can affect people's behaviour and engagement with services can result in services excluding or re-traumatising people. This can be a substantial barrier to people getting support. For further information on the benefits of a trauma-informed approach to supporting people experiencing multiple disadvantage, see our recent review of evidence on the topic.[15]

Until recently there has been a lack of consensus within the health and social care sector on how trauma-informed practice is defined, what its key principles are and how it can be built into services.[16] The Office for Health Improvement and Disparities now offers a working definition of trauma-informed practice, which comprises:

- Realising that trauma can affect individuals, groups and communities – trauma exposure can impact an individual's neurological, biological, psychological and social development.

- Recognising the signs, symptoms and widespread impact of trauma – trauma can negatively impact on individual's ability to feel safe or develop trusting relationships with services and their staff.

- Preventing re-traumatisation – re-traumatisation can be triggered by reminders of previous trauma. The purpose of trauma-informed practice is not to treat trauma-related difficulties but address the barriers to accessing services that people can experience due to their experiences of trauma.

The same definition offers six principles of trauma-informed practice: safety, trust, choice, collaboration, empowerment, and cultural consideration.

Interviewees were asked to explain what trauma-informed practice meant to them. Across the local Changing Futures areas, stakeholders generally related to this working definition, although there were some differences and more/less emphasis placed on specific components. Generally, service delivery staff and strategic stakeholders had similar understandings of trauma-informed practice. Stakeholders across the sampled areas referenced all of the six principles of trauma-informed practice, particularly emphasising the importance of forming trusting, respectful relationships and working in a relational way, which was seen as a necessary first step of trauma-informed practice.

[Trauma-informed care is] about relational work, whether that is people we are supporting with multiple disadvantage or each other. Connecting as humans, understanding people are people. It's more than being compassionate, it is about not judging, being transparent in thinking. Convey empowerment and value everyone's voice.

Changing Futures programme team member

The starting point for trauma-informed practice in Changing Futures areas

As a result of a range of initiatives, there is now greater recognition of trauma-informed practice and there has been a shift towards embedding it in all of the sampled areas. Most professionals interviewed have been aware of the concept for some time and stakeholders reported that attitudes towards trauma-informed practice are now more favourable.

Across areas, a variety of work to embed trauma-informed practice across local systems pre-dates the introduction of Changing Futures. All of the sampled areas were either part of the MEAM Approach Network or the Fulfilling Lives programme, both of which aimed to improve outcomes for people experiencing multiple disadvantage and change the local system, with a distinct focus on embedding trauma-informed practice. Additionally, most sampled areas have regional trauma-informed networks which were established before the Changing Futures programme. These networks provide opportunities for professionals to meet and reflect on trauma-informed work, share insights and ideas, and access training. Even in areas where there is not an established network, professionals have had access to relevant training.

Nevertheless, sampled areas and other programme areas identified a number of barriers to embedding trauma-informed practice prior to Changing Futures. These included high caseloads among staff supporting people with experience of multiple disadvantage; staff not always feeling supported and having the skills to do their jobs effectively; and inconsistent adoption and application of person-centred and trauma-informed practice. These informed the programme's theory of change and were also identified as part of local systems mapping exercises(see the baseline report). Accordingly, sampled areas are aiming to:

- assist services supporting people experiencing multiple disadvantage (including both Changing Futures direct services and other services) that are carrying high volume, challenging caseloads and have limited capacity,
- improve support for the workforce to ensure they feel supported and have the skills to do their jobs effectively, and
- further improve understanding of trauma-informed practice and help services to follow a consistent approach.

3.2 Programme activities

Key points

- Changing Futures teams support participants using a caseworker model. This embodies the key principles of trauma-informed practice.
- Caseloads of between 7 and 12 enable caseworkers to build understanding and trusting relationships. They focus on supporting participants to make decisions about their lives and the support they need.
- Caseworkers and other Changing Futures funded staff in sampled areas have access to a wide range of training opportunities and participate in reflective practice.
- Changing Futures areas are encouraging the wider system of services to be more trauma informed. The main ways of doing this are Changing Futures caseworkers demonstrating a different way of working; provision of training and related resources; dedicated roles to promote trauma-informed practice; building relationships, partnerships and/or dedicated groups; and embedding lived experience in service redesign.

Delivering a trauma-informed approach

One of the core principles of the Changing Futures programme is that each of the funded areas takes a trauma-informed approach, in supporting participants, across their local services and systems change work and in the governance of the programme.

All sampled areas have either introduced or continued to use a multiple disadvantage caseworker model. The model consists of a caseworker (also known as a “navigator”, “coordinator” and “key worker”) who works with people on the Changing Futures caseload and coordinates other services involved in their support. The caseworker model is fundamental to the themes explored in this round of qualitative research. The key components of the model are described in this section but referred to throughout the report.

Across Changing Futures areas, the caseworker model focuses on operationalising the six principles of trauma-informed practice. Caseworkers have the autonomy and capacity to work holistically and relationally with people, and provide tailored, person-centred support. **Caseworkers typically have small caseloads**, especially in comparison with similar services. A recent report from the Centre for Homelessness Impact indicates that the average caseload size for standard (less intense) case management for people experiencing homelessness is 35.[17] Average caseload sizes in Changing Futures areas range from 2.5 to 17.6, with most areas having an average caseload of between 7 and 12.

The Fulfilling Lives evaluation reported caseload sizes of between 6 and 10 as optimal for this cohort.[18]

Smaller caseloads give staff the capacity to spend more time with participants and to develop strong and trusting relationships with them. This was said by interviewees to be particularly important when a participant first accesses a service, as it enables them to build an understanding of the participant's story, challenges, and their support needs.

It's all about strong working relationships. [Caseworkers] are good at reading people and knowing what you need.

Programme participant

As part of their work, **caseworkers empower participants** to help them get to a position where they can make decisions about their own lives and the support they receive. As a strategic stakeholder in South Tees reported, the ethos of the programme is "*empowering people to lead more fulfilled lives".* Participant interviewees indicate that they feel empowered to make choices and are treated with respect by programme staff. Caseworkers typically do not have a set agenda. Their work is guided by the individual participant and they have the time to explore a variety of support options.

I'm not talked down to by Changing Futures staff. I'm treated as an equal.

Programme participant

People in roles funded by Changing Futures, including caseworker, have **access to bespoke training** to develop their skills and improve practice – both as part of their induction and on an ongoing basis. Areas offer a wide variety of training, including the local Changing Futures approach, multiple disadvantage, trauma, mental health first aid, use of data systems, and collective risk taking. There are also opportunities for Changing Futures teams to engage in reflective conversations to improve their practice, embed trauma-informed working, and get emotional support. These activities are discussed further in section 3.5.

Stakeholders reported some challenges to working in a trauma-informed way and these are further explored in section 5.1.

The Liberated Method in Northumbria

The Changing Futures team in Northumbria has developed a model called the liberated method. While local stakeholders do not refer to this as trauma-informed practice, it does incorporate many of the core principles. The liberated method has been developed as a series of prototypes over the last five years and focuses on providing increased freedom for caseworkers, as well as liberating leadership, partnership, commissioning and governance.

Participants are supported by caseworkers and peer support specialists working in pairs who have the autonomy to provide tailored, person-centred support. Caseworkers and peer specialists said that this has improved their job satisfaction, as they have been able to work collaboratively, share risk, and find solutions to challenges together. The scope of support that they can provide is broad, as long as they follow two rules: 1) stay legal and 2) do no harm. This means that the team must balance helping participants to achieve their goals in the ways they choose while also supporting them to manage the risks. This can be more challenging to implement than an approach which has more defined support measures.

Five guiding principles enable caseworkers and peer support specialists to make decisions based on what matters to the individual being supported. These are:

- Understand, don't assess. People are identified for the programme through two touchpoints (see page 50). There are no set criteria for determining what type of support they will receive. Instead, caseworkers get to know people and support them to identify and work towards goals that are important to them.
- The caseworker and participant set the scope. Caseworkers are encouraged to think creatively and (within reason) nothing is out of scope. This means the offer of support is tailored to each participant.
- Caseworkers and peer specialists are empowered to make decisions. Operational teams are encouraged to ask for advice but not for permission.
- Cases are not closed unless a person requests it during the time the programme is operating.
- Specialists are brought in to provide support. The caseworker holds overall responsibility for the case and invites specialist services in when necessary to support the participant. The caseworker remains their 'go to' person and helps them 'pull in' any specialist services they need.

The participants that we spoke to were extremely positive about the support they have received from their caseworkers. They reported that support has been flexible and tailored to them. Most commonly, participants were grateful that they had a consistent person in their life who was there when they needed them.

Working to make services more trauma-informed

An important part of the programme locally is its ability to **demonstrate a different way of working**. Caseworkers and other programme staff draw on their understanding of trauma to support other services to follow Changing Futures' lead and become more trauma-informed. We heard from multiple caseworkers that they have conversations with professionals across the system to advocate for their clients and share information about participants, including their background and story, to increase understanding about the challenges they face and how these can affect the way they engage with services.

The programme has **provided or supported training and consultation for professionals and organisations** to improve their understanding and practice of trauma-informed approaches. Across sampled areas, training has been made available for the wider system and to different levels within organisations. For example, in Stoke-on-Trent, the INSIGHT Academy, developed as part of Changing Futures, has delivered 120 training sessions to over 1,900 attendees. The Academy helps to fill gaps in skills and knowledge and has helped design trauma-informed training for adult social care professionals, which has now become mandatory in the local area. Similarly in Surrey, the programme has been working alongside the Trauma-informed Network to deliver training and consultation opportunities, helping the Network to expand its offer to more services and professionals.

In several areas, the programme has **developed resources that can be used by professionals to improve practice**. These include a Collective Safety Planning Toolkit in Bristol to highlight how services can work together to share risks and accountability, empowering and supporting staff in positive risk-taking when they work with people. A Surrey-wide trauma-informed framework is being developed by the Trauma-informed Network. There are ten domains, which organisations can measure themselves against to see how trauma-informed they are.

Dedicated, specialised roles that focus on trauma-informed practice, as well as principles such as cultural competency and equality, diversity and inclusion (EDI), have been established in a number of areas. These include the EDI Lead role in Bristol, which addresses accessibility issues and advocates for neurodiverse people, and a trauma-informed lead role in South Tees, created to disseminate knowledge, build relationships, and ensure there is an ongoing focus on trauma-informed practice across the system. One area has introduced trauma-informed champions, placing 17 champions in different organisations to promote a culture shift towards trauma-informed approaches.

There are examples across areas of Changing Futures helping to embed a trauma-informed approach through **building relationships, forming partnerships and organising dedicated groups**. These groups and partnerships provide a platform to broadcast the work of the programme locally and embed trauma-informed approaches. For example, the programme team in Stoke-on-Trent is fostering partnerships in the health sector, collaborating closely with the Integrated Care Board to develop trauma-informed practices. Various groups have been established in Bristol, such as the Cross Sector Manager Group and the Learning Collective, which allow professionals to discuss strategic goals and promote trauma-informed approaches, with monthly training sessions.

There are still a good number of people who don't know what multiple disadvantage means. It's reframing the way people talk, the words they use, and in turn how they see and support people.

Changing Futures programme team, clinical psychologist

The programme continues to provide **opportunities for people with lived experience to contribute to the design, development and coordination of services**, including inputting on how services could be more trauma informed. Most commonly, this is enabled through recruiting lived experience leads, who convene and coordinate a group of people with experience of multiple disadvantage. Lived experience networks provide opportunities for people to engage in system conversations and contribute to service design and delivery. The role of lived experience in contributing to service and system change was explored more fully in the previous interim report.

3.3 Supporting the workforce

Key points

- Sampled areas have introduced a range of support for people employed by the programme, especially caseworkers. This includes regular supervisions, support from a clinical psychologist, reflective practice sessions, flexible working, away days and provision of training and therapies.
- Local leaders hope that by gathering evidence of the impact of adopting trauma-informed practice and inviting other services to see what Changing Futures is doing, the programme will encourage others to take a similar approach.
- The more trauma-informed approach of Changing Futures has resulted in staff gaining greater job satisfaction than in previous roles.
- Induction, training and learning activities are helping to empower Changing Futures staff and encourage critical thinking. Staff have received positive feedback from colleagues and other professionals report learning from their approach.

Working to support people experiencing multiple disadvantage can be challenging: the majority of Changing Futures beneficiaries will have experienced considerable trauma in their lives. With that comes high levels of distress, risk of harm to themselves and others and, in many cases, repeated crises resulting in interventions from emergency services and the criminal justice system. Premature death is far more common for this group than for the population as a whole. When those working to support beneficiaries, whether in a paid or voluntary role, have limited access to specialist supervision and support, they can experience second-hand trauma and/or burn out.[19,20] The Changing Futures programme recognises this challenge and local areas are trialling approaches to better support the workforce. This section outlines the key activities areas are implementing locally to support the Changing Futures workforce. These encompass psychological wellbeing, skill development, team cohesion, and recognising diversity in the workforce. Some of these approaches are more innovative and experimental in the context of services for people experiencing multiple disadvantage, while others would probably be considered well-established good employment practice. Assessing the effectiveness of these approaches is outside the scope of this evaluation.

Interviewees reported that **programme managers consider the wellbeing of their staff**. In Surrey, the programme team has started to use referral panel meetings to assess the wellbeing of both caseworkers and service users. Similarly in Bristol, team managers have regular conversations with caseworkers about their caseloads and wellbeing. They have also introduced a staff survey, creating space for the wider team to take collective responsibility for addressing issues.

In most sampled areas, the Changing Futures workforce receive **regular one-to-one supervisions**. These sessions provide an opportunity for staff to address any emerging support needs or challenges, to reflect on anything that might be stressful or traumatising and provide an opportunity to consider ways to improve practice. Supervisions are used to talk about specific cases. Interviewees regarded supervision as an important component of support because it provides staff with space to consider the emotional impact of their work.

Bristol and Surrey have employed **a clinical psychologist to provide supervision, support the workforce and help embed trauma-informed practice**. While delivery staff often support people with a range of clinical support needs, they have previously struggled to access specialist advice because they are employed outside of a clinical setting. The clinical psychologists do not support participants directly, but instead advise caseworkers and other staff on best practice and provide expert knowledge. Interviewees praised the level of expertise offered by the clinical psychologists.

The clinical psychologist also does one to ones with [workers]. She sees them quite regularly, one to one, but if somebody has… a particular issue, they can pick up the phone and call her. She's there for them… She's employed to support them in whatever they need, and some of them need their own support. They've been traumatised in past jobs with the VCSE organisations.

Strategic stakeholder, VCSE partner organisation

Across Changing Futures areas, a variety of **reflective practice and team cohesion activities** have been introduced. It was common for staff in sampled areas to attend group sessions and team meetings regularly. For example, in Stoke-on-Trent, reflective practice sessions have been introduced that include learning activities; these are often shaped by the discussions that take place between staff. In Bristol, the Changing Futures team is trialling 'compassionate circles', where the team takes time out to connect with each other and share gratitude. There are also 'lunch and learn' sessions for staff, where they engage in reflective practice.

In addition to the training opportunities described in section 3.3, the Changing Futures team in South Tees has had **access to training focused on wellbeing and stress management**.

A lot of the training is sort of customer related, but a good percentage of it is how we look after ourselves as well, self-care.

Changing Futures programme team member

We also found examples of actions to ensure work-life balance and staff wellbeing, including more manageable workloads, **flexible working practices, therapies and away days**. For example, in Bristol a yoga teacher comes into the office, while in South Tees, a programme team member provides acupuncture for staff and participants.

While the Changing Futures programme has delivered formal training and created networking opportunities for professionals across the system (as discussed in section 3.4), the extent to which it can provide direct support for the wider workforce is limited by the available resource. Instead, interviewees indicated that areas are testing initiatives and building an evidence base for other services to learn from. The programme teams in multiple areas have shared information with other services on the impact of specific activities, such as reflective spaces. Some areas have also invited professionals from other services to attend activities. For example, in one area, staff from local VCSE organisations were invited to participate in reflective sessions, to consider challenges and generate solutions. It was initially challenging to get people to engage, so they developed a questionnaire for staff to express what they wanted to get out of sessions. This resulted in higher attendance, and those who took part reported that they found the sessions useful.

Impact on the Changing Futures workforce

Caseworkers and other Changing Futures programme staff often reported **increased levels of job satisfaction**. Stakeholders put this down to:

- agreeing with the approach and overall ambition of Changing Futures
- working closely with participants and having the time to develop meaningful relationships
- small caseloads that enable them to make a difference, and
- increased levels of flexibility and autonomy compared to previous roles.

Interviewees were extremely positive about their ability to focus on the needs and wants of participants, rather than having to deliver a specific pathway of support. One caseworker shared that they are “living the dream” and feel empowered to do the work they want to do.

It has been really positive. Everyone is motivated and it has had a profound impact on my personal happiness. This is caused by the increase in autonomy. We all have to work the core hours which are 10am to 3pm but have flexibility around this, which means I can miss the traffic and also have more capacity to deal with people.

Changing Futures caseworker

The staff support described in section 3.5 is clearly valued by interviewees. Whether it is receiving advice and emotional support when dealing with a tricky situation or being able to discuss different approaches with other team members, **Changing Futures staff feel supported**. However, it has been difficult for some areas to maintain time for staff support activities, such as supervisions, as the programme team has become increasingly busy; this has resulted in occasions when staff have felt less supported.

I think I've had a couple of people that have been quite complex, and one has passed away and I don't know how that would have been if I hadn't been having supervision where I could discuss things and make sure I'm doing the right things and handling things the right way… I have found it very helpful.

Service delivery staff member

Resilience is an important quality of successful caseworkers. They constantly face complex situations that can impact on emotional wellbeing. Several partnerships highlighted the value of **regular reflective practice to build caseworker resilience**.

Reflective practice provides an opportunity for caseworkers to share concerns relating to the role and, importantly, to resolve issues and move on.

Interviewees were also positive about the induction, training and learning activities provided. The **training is helping to empower the workforce and encourage critical thinking**. For example, one caseworker reported that training had helped them speak up when a more senior member of staff told them to do something that conflicted with trauma-informed practice. Another adjusted their pace to better match a programme participant following training. Although some stakeholders commented that the training sessions did not always cover new content, there was general agreement that it is important to reinforce positive ways of working. A minority of caseworkers reported that they did not feel the need to attend training sessions because they had attended similar training previously and/or had a background which used similar approaches. Some caseworkers have received positive feedback from colleagues across the system and other professionals said they had learned from Changing Futures' trauma-informed approach.

3.4 Impact on participants

Key points

- Small caseloads and trauma-informed approaches help caseworkers build trusting relationships with participants and provide tailored support. This leads to better engagement with Changing Futures and other services.
- There is a statistical association between lower caseload sizes and lower levels of participant need and risk.

The stakeholders who took part in the qualitative research identified several benefits for participants of the trauma-informed approach.

Participants have developed strong and trusting relationships with caseworkers. For many participants that we spoke to, this was the cornerstone of the support that they have received.

They provide flexible support and its person centred. It takes a lot of time to build up a relationship; it's hard to do this in a 10-minute appointment.

Programme participant

These relationships allow participants to be open about their past experiences, needs, and aspirations and caseworkers have the flexibility and autonomy to respond, for example, by providing more intensive support at the outset, or supporting participants if they find it overwhelming to work with multiple services at once, caseworkers adjust their approach.

I tell [my caseworker] what I need and then they make suggestions. They really know their clients.

Programme participant

Participants reported that **improved experiences of the support they receive**. They feel valued and cared for by their caseworker.

Compared to other services, Changing Futures spends a lot more time with you and are a lot better.

Programme participant

As a result, interviewees perceive that participants not only have improved engagement with the Changing Futures programme they also have **improved engagement with other services** that their caseworker is helping them to access. Participants are "*asking for help and having their voice heard"*. We heard many positive stories about improved participant outcomes, including being housed in permanent accommodation, receiving benefit entitlements and rebuilding relationships with family members.

[My caseworker] just doesn't give up. Before they would just pass us from pillar to post and wouldn't change anything. [My caseworker] knows when you're ready for support and helps me access it.

Programme participant

We explored the effect of caseload size on outcomes as part of our regression modelling (see pages 83 to 86). There is an association between caseload size and change in NDTA score – **those participants getting support from areas with lower caseloads were more likely to experience an improvement of their assessment score – indicating lower levels of need and risk** (see Table A2.52). This fits with the qualitative insights that smaller caseload sizes facilitates greater engagement and better outcomes.

3.5 Impact on the wider system

Key points

- There is evidence of progress towards more trauma-informed local systems, although the extent of this progress across the areas is mixed.
- Interviewees agreed that awareness of multiple disadvantage and trauma in their areas has increased and were confident about the benefits of the training Changing Futures has been delivering.
- A substantial majority (81 per cent) of respondents to the follow-up partners survey had received training in trauma-informed working, with most receiving it in the past year.
- Interviewees were less confident about the impacts on the system beyond increased awareness of trauma and trauma-informed approaches.
- However, our follow-up partners survey shows progress in how well organisations support both their staff and clients. Almost all respondents indicated they are delivering key elements of trauma-informed support.

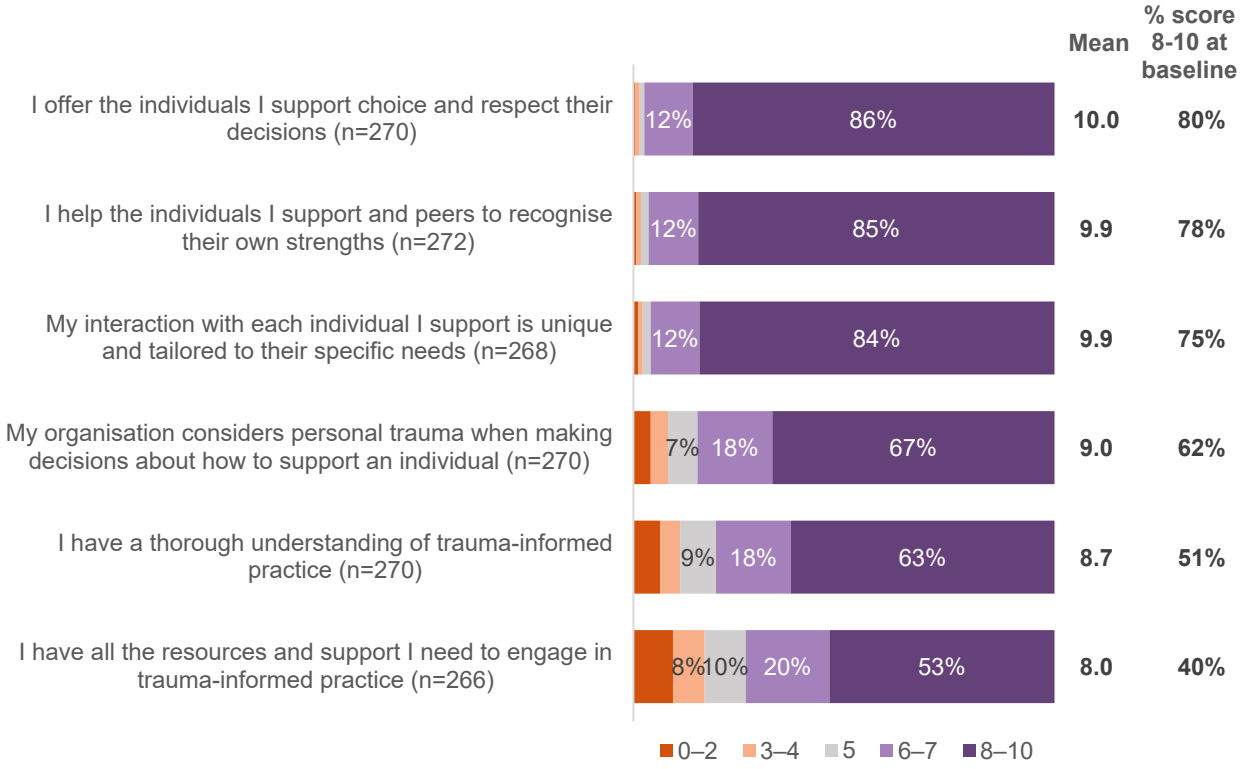
Across sampled areas there was a general consensus that the Changing Futures programme has **improved awareness of multiple disadvantage and the impact of trauma** amongst services that come into contact with people experiencing multiple disadvantage. Professionals are increasingly able to recognise trauma and understand the impact it can have on a person's behaviour. Stakeholders argued that awareness raising and training were a necessary part of the journey towards embedding trauma-informed approaches across the system. Interviewees also reported that there has been an increase in the number of people talking about trauma-informed practice and there is interest in learning more, with new professionals and organisations signing up to Changing Futures activities.

The results of the follow-up partners survey, administered just over year after the baseline survey, provides evidence of **increased training on trauma-informed practice**. A substantial majority (80.8 per cent of respondents, n=281, see Table A3.1) reported receiving training related to trauma-informed practice. In the baseline survey, 69 per cent (n=271) of respondents reported this. In both surveys, most respondents reported participating in training relatively recently: for instance, 59.5 per cent of respondents to the follow-up who had received training, had received it in the last 12 months (see Table A3.2). Knowledge of trauma-informed practice appears fairly widespread amongst stakeholders, with 63 per cent of respondents (n=270, see Figure 3.1) strongly agreeing

that they have a thorough understanding of trauma-informed practice – this compares to 51 per cent at baseline.

The results of the follow-up partners survey present a positive picture of trauma-informed practice. As can be seen in Figure 3.1, a **high proportion of respondents reported implementing different aspects of trauma-informed working**. Almost all respondents (98 per cent, n=270) tended to agree that they offer the individuals they support choice and respect their decisions. Similarly high proportions agreed that they help people recognise their strengths (97 per cent, n=272) and that they tailor their interactions to individuals (96 per cent, n=268).

Figure 3.1: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?



Whilst momentum is building around trauma-informed approaches, many interviewees were hesitant to state definitively what changes had occurred at a system level as a result of the networks, forums, and training delivered through the programme. There was a sense that it was 'too soon' to fully understand the wider impact on professional practice. Generally, **interviewees struggled to identify changes in the behaviour of professionals outside of Changing Futures or to the structures and policies of services**. It was noted that many services adjust their behaviour when communicating with

a caseworker, but stakeholders were unsure whether services would be as responsive when working directly with a client.

The survey results also support interviewees' reservations about the extent to which trauma-informed working is happening across the whole of local systems, with a number of respondents commenting on the variability in practice between voluntary and statutory sectors, amongst different service sectors, and even between teams within the same organisations. On average, voluntary and community sector respondents had greater agreement than statutory sector respondents that they supported individuals in a trauma-informed way. Voluntary sector respondents also had greater agreement (mean=8.7) than statutory sector respondents (mean=7.0) that their organisation considers personal trauma when making decisions about how to support an individual.

The reasons for the difference between statutory and voluntary, community and social enterprise (VCSE) survey responses is unclear. Some hindrances to trauma-informed working, notably scarce resources, were reported by both VCSE and statutory sector respondents. However, both negative cultures and inflexible requirements and procedures were linked in several responses specifically to the statutory sector: 'It can be challenging to work within these [NHS] structures and to constantly try to change practice. So even if our team works flexibly and adapts our service to people with MDs [multiple disadvantage], the system is clunky and inflexible.'

Training and organisational support also appears to be meeting the needs of workers. Most respondents (83 per cent, n=485) to the follow-up partners survey tended to agree that they have access to the training they need to maximise their confidence and skills in their role (see Figure 3.282). Additionally, survey responses indicate that training activity is occurring at least to some extent due to organisational behaviours rather than only on the initiative of individual staff members: 79.2 per cent of survey respondents (n=491, see Table A3.3) reported that their organisation regularly or sometimes participated in joint staff/volunteer training with other organisations involved in the local system.

When asked about resources, time, or support, survey respondents were less positive: only 67 per cent of respondents tended to agree they have the time and resource needed to perform their roles (see Figure 3.2), and 73 per cent tended to agree they have the resources and support needed to engage in trauma-informed practice (see Figure 3.1). However, levels of agreement to these questions were higher than the previous year survey when 64 and 68 per cent of respondents, respectively, tended to agree. At the same time, voluntary and community sector respondents were, on average, more likely to agree that they had the time and resources needed for their roles than statutory sector respondents (mean agreement of 7.0 versus 6.0) and the resources and support for trauma-informed practice (mean agreement of 7.5 versus 6.3.).

Figure 3.2: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?

4 Joining up support around the service user

A core aim of the Changing Futures programme is to assist participants to get the support they need when they need it. In this chapter, we explore how the programme is working to join up support around the needs, preferences and aspirations of programme participants. We begin by presenting quantitative analysis of outcomes questionnaire data to show which services and types of support people are getting and how these change over time. We are generally looking at change over participants' first 12-months on the programme. First follow-up questionnaires are completed, on average, approximately 5 months after joining the programme. Some participants will have received several months of support before providing baseline data and so not all change is captured. We report regression analysis which identifies links between participants receiving support and achieving key outcomes.

The chapter then goes on to explore the range of activities being used by Changing Futures areas to improve participants' access to and experience of services. It includes how people at risk are identified and referred to Changing Futures. These findings are based on the qualitative research in sampled areas. The final three sections of the chapter set out evidence from both the qualitative research and the partners survey on the perceived impact of these activities on individual participants, local services and the wider system.

4.1 Use of core services

Key points

- There are few significant changes in the overall proportion of people in contact with core services (mental health, drug and alcohol, homelessness, domestic abuse and probation services). While some participants move to being in contact with services over time, others stop being in contact with services.
- Recent contact with mental health services is associated with improved ability to cope with mental health problems and with reduced homelessness.
- There is a sharp increase between baseline and first follow-up in new people accessing homelessness services. This pattern suggests the programme is taking steps to address acute needs for the most urgent cases early on.
- The overall proportion of people in contact with the probation service decreases between baseline and first follow-up. After the first follow-up point, the rate at which new people have contact with probation begins to slow.

In this section we explore participant use of core services designed to directly address forms of disadvantage. These are mental health, drug and alcohol, homelessness, probation and domestic abuse services.

Mental health services

As we reported in the previous interim report, there are few significant changes in the overall proportion of people who have had recent contact with core services between baseline and first follow-up. However, just looking at overall percentages hides changes in how people engage with services over time. While 12 per cent of people with a mental health problem at baseline had moved to being in contact with services by first follow-up, 14.9 per cent were no longer in contact with services. We do not know the reasons for this - it could be for positive reasons (they had had their needs met) or more negative reasons – such as being placed on a waiting list, refused support or just did not sustain contact. Positively, 36.2 per cent of people with a mental health need were in contact with services at both time points, but a similar proportion (36.8 per cent) of people with a need were not in contact with services at either point. It is also important to note that 'contact' with a service does not necessarily mean receiving treatment.

As we explore in section 5.2, access to mental health services can be particularly challenging. Better access is important for a number of reasons. **Our regression analysis shows that participants with recent contact with mental health services are more likely to report improved ability to cope with mental health problems** (Table A2.57). Contact with mental health services is also associated with reduced homelessness (Table A2.43). The Fulfilling Lives evaluation found similar results – use of counselling and other mental health therapies was associated with improvements in wellbeing.[21]

Drug and alcohol services

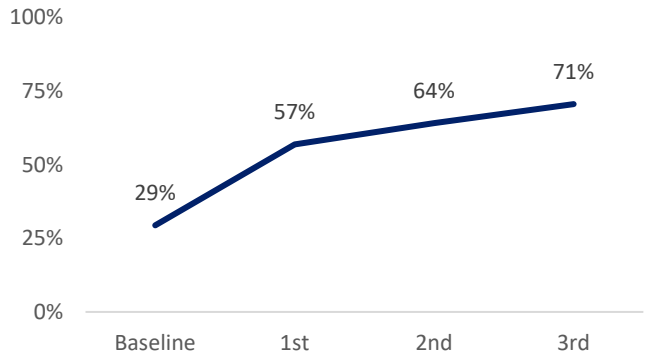
Patterns of contact with drug and alcohol services are similar to those for mental health. There is **no significant difference in the overall proportion of people with a drug or alcohol need who have had recent contact with services at baseline and first follow-up** (See Table A2.53). This is explained by the fact that a few people who were in contact with services at baseline, were no longer in contact with services at follow-up. Others, who were not in contact at baseline were at follow-up. These two changes result in no significant change overall. As with mental health services, we do not know the reasons for this, but given the complexity of people's needs and the likely length of time required to address these, we might expect to see more sustained contact with these services rather than occasional engagement.

We found no significant associations between contact with drug and alcohol services (or any other of the core services discussed in this section) and participants' ability to cope without using drugs and/or alcohol (Table A2.26). As set out in section 2.1, addressing drug and/or alcohol problems is a long-term endeavour and relapses are frequent.

Homelessness services

Again, there is no statistically significant change in the overall proportion of people with a homelessness need who have had recent contact with homelessness services between baseline and first follow-up (see Table A2.53). Similar proportions start and stop being in touch with services. However, unlike contact with mental health and drug and alcohol services, contact with local authority homelessness services should be brief. If we look at everyone since the start of the programme who reported contact with homelessness services in at least one of the first four questionnaires (Figure 4.1), we see a sharp increase in the proportion that was in contact with homelessness services between baseline and first follow-up (from 29 per cent to 57 per cent). This pattern suggests the programme is taking steps to address acute needs for the most urgent cases early on.

Figure 4.1: Proportion of participants who have ever been in contact with homelessness services between baseline and third follow-up questionnaire (base=187)[§]



However, as reported on page 18, the overall proportion of people experiencing homelessness does not change. Furthermore, **contact with homelessness services is associated with a greater likelihood of recent experience of homelessness** (Table A2.43). This may appear counterintuitive but could simply reflect the fact that the people most likely to access these services are those in greatest need and whose situations have not yet improved.

Probation service

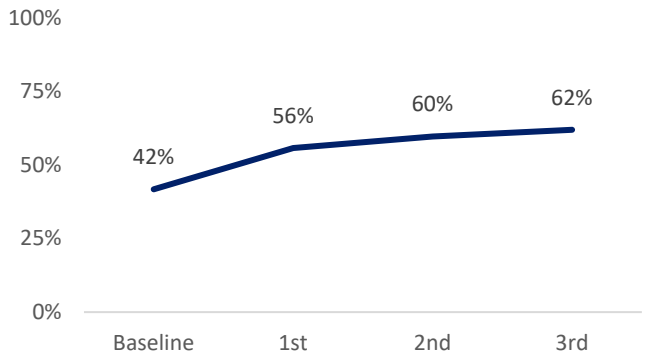
The **proportion of people with recent contact with probation decreases** from 34.8 per cent at baseline to 29.5 per cent at first follow-up (n=650, see Table A2.53). Probation is different to the other services explored. Unlike other services, attendance is mandated by the criminal justice system and results from offending behaviour, and non-attendance has negative consequences, including recall to prison. This makes it difficult to interpret

[§] Base size is small due to tracking change of a consistent group of people over four questionnaires.

whether overall changes in engagement represent an improvement or not. For instance, a decrease in contact with probation could be the result of reduced offending, but it could also be a signal that people are not complying with the conditions of their probation.

Looking at people since the start of the programme who reported contact with probation services in at least one of the first four questionnaires, there is a marked increase in the proportion that has been in contact with this service between baseline and first follow-up (from 42 per cent to 56 per cent. See Figure 4.2). However, after that **the rate of increase in noticeably slows with fewer new people having contact with probation between the first, second and third follow-up points**. This could be interpreted positively if we take new contact with probation as a proxy for offending behaviour.

Figure 4.2: Proportion of participants who have ever been in contact with probation services between baseline and third follow-up questionnaire (base=175)[**]



Irrespective of experience of disadvantage, **those participants who had contact with all five core services (drug and alcohol, domestic abuse, homelessness, mental health and probation) in the previous three months were more likely to have a worse quality of life (as measured by ReQoL score) at their first follow-up compared to baseline** (see Table A2.8). This could be interpreted as an indication that those whose wellbeing is getting worse are more likely to be accessing multiple services. It also aligns with findings from the qualitative research that indicate, because of the high threshold for accessing services, people sometimes need to reach crisis point before being offered support.

[**] Base size is small due to tracking change of a consistent group of people over four questionnaires.

4.2 The role of other services and support

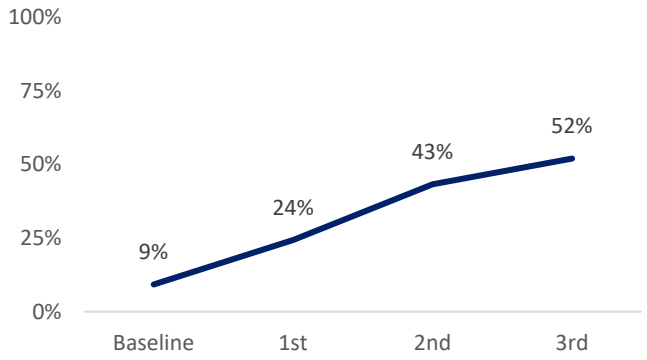
Key points

- There is a significant increase in the overall proportion of people contacting services other than the core services described in the previous section.
- There are marked increases in people getting support such as thinking about wellbeing and personal goals and help with benefit applications, between baseline and first follow-up. Other support activities appear to be more important later on in the journey, such as help with maintaining and cleaning accommodation.
- Getting help to attend appointments and access a GP appear to be needed by a high proportion of people at different stages of the journey. Support to access employment or training seems to be of lower importance for many.
- People who get help attending appointments are more likely to also have improved scores on the NDTA, which includes an assessment of how well participants are engaging with services.
- The more types of support people receive the more likely they are to report improved quality of life.
- Few specific support activities are consistently associated with positive outcomes. However, there are links between being introduced to local community groups and reduced homelessness and increased confidence in being in stable accommodation in six-months' time.

Unlike most of the core services described above, there is **a significant increase in the proportion of people in contact with 'other' services** between baseline and both first and second follow-up (see Tables A2.53 and A2.54). The questionnaire does not ask respondents what these services are, but other questionnaire responses, including open questions, indicate this could include physical healthcare and welfare rights/money advice.

The trajectory of all those who have ever had any contact with 'other' services (see Figure 4.3) increases steeply from a low starting point at baseline over all three follow-up points. These findings fit with qualitative research findings which show Changing Futures caseworkers helping participants to access a wide range of complementary support (such as mutual aid, therapeutic social and arts activities) alongside efforts to access core services and emphasises the importance of diverse and whole person support.

Figure 4.3: Proportion of participants who have ever been in contact with 'other' services between baseline and third follow-up questionnaire (base=173)[††]



Participants get support with a wide range of activities such as benefits applications, attending appointments and (re)connecting with family members. By plotting the proportion of participants who reported ever having help with these activities over four time points, we can also see how priorities change over time – see Figure 4.4 and Table A2.56 (base sizes are small because we are tracking people over four follow-up points). **Some key support activities show a marked increase in people getting this help between baseline and the first follow-up**, such as thinking about wellbeing and personal goals and help with benefit applications. **Other support activities appear to be more important later on in the journey**. For example, while a large and increasing proportion of participants reported getting help to address housing problems early on in the programme, relatively few reported getting help maintaining accommodation, although the proportion who have received this help does start to increase, particularly between the second and third follow-up points.

The proportion of people who have at some point had help to attend appointments and access a GP continues to increase markedly, even after the first follow-up. This could be argued to highlight the ongoing importance of this type of support to people. By the third follow-up, 85 per cent of people with data at all time points have received help attending appointments at some point since joining the programme (n=183). 72 per cent have received help accessing a GP (n=181).

In contrast, **very few people reported receiving support to access employment or training** at baseline (2 per cent). And while this increases to 15 per cent of people by the third follow-up, this appears to be a lower priority for many than other types of support. The programme is targeting people with the most entrenched needs and who are not already engaging well with services. Qualitative insight from caseworkers indicates that for those people with the most chaotic lives, thinking about employment and training is a long way

[††] Base size is small due to tracking change of a consistent group of people over four questionnaires.

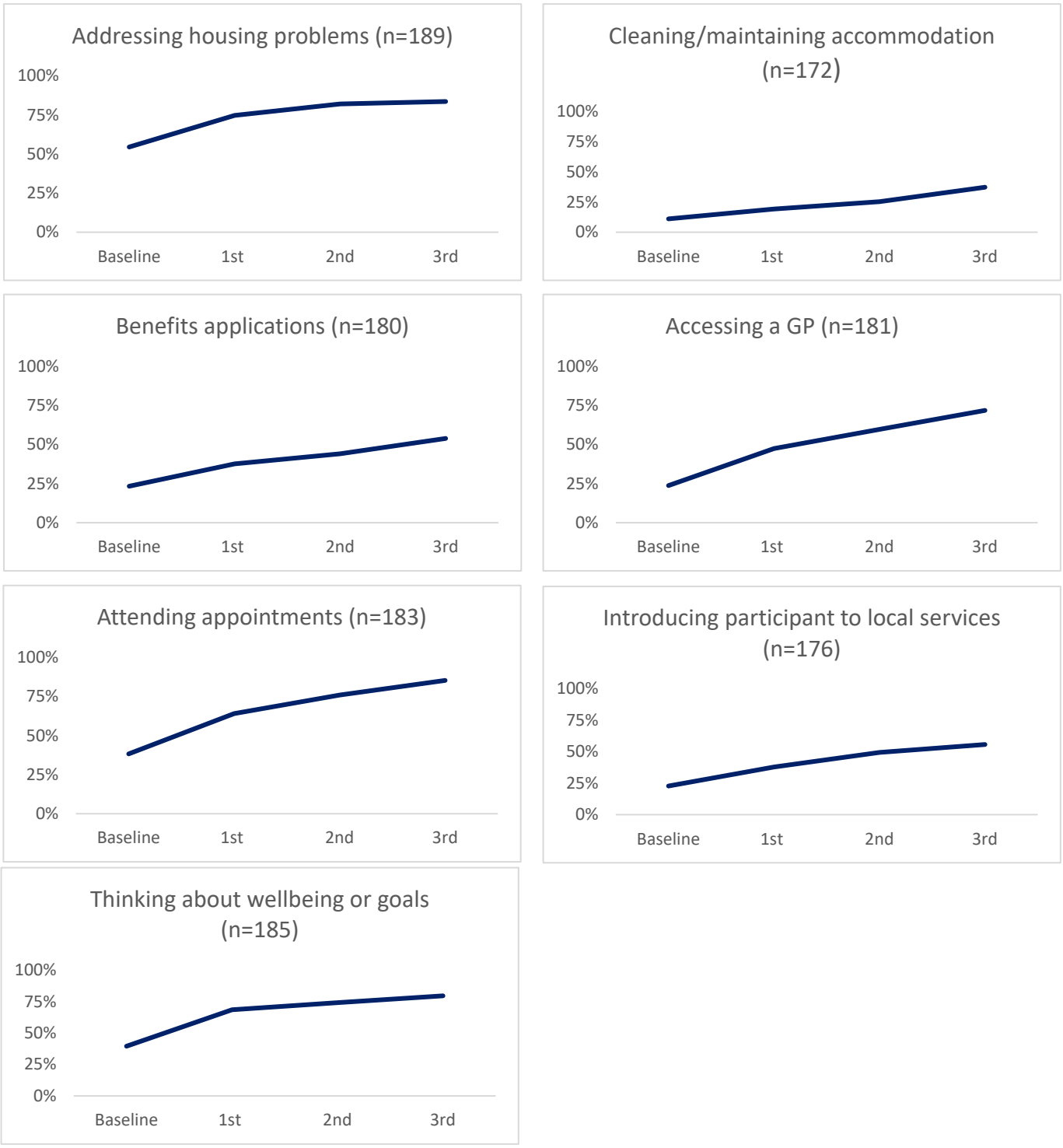
off, and may not be feasible for some people who are likely to need support for the rest of their lives.

The quantitative data by its nature does not capture the highly personalised support that Changing Futures aims to provide. The following feedback, provided by a participant in their questionnaire on what support had been important to them, illustrates how more unusual but also relatively simple assistance can make a difference to people's quality of life.

Support from Changing Futures when the animal control people were threatening to take away my chickens - they bought me a coop and run and installed it, and now the animal control people haven't been bothering me anymore. My chickens are very important to me.

Changing Futures participant

Figure 4.4: Proportion of participants who have ever received different types of support between baseline and third follow-up questionnaire‡‡



‡‡ Base sizes are small due to tracking change of a consistent group of people over four questionnaires.

We explored the links between getting support (such as attending appointments, benefits applications and so on) and outcomes. Results here are mixed (see Table A2.58); **few support activities are consistently associated with positive outcomes.** This could be due to relatively small sample sizes and the fact that only a few people are getting support with some activities. However, the qualitative research findings also emphasise the importance of personalised support – the type of support that makes all the difference for one person might not have the same effect on another. Further, the regression does not account for other unobserved factors that may be crucial – such as providing support in a compassionate and trauma-informed way.

We report here just a few of the significant associations where the results corroborate the qualitative research or evidence from outside the Changing Futures programme. Throughout this report we have highlighted the **importance of support with attending appointments**, including transport to appointments. **People who get this support are more likely to also have improved scores on the NDTA, which includes an assessment of how well participants are engaging with services**. Help attending appointments is also associated with improved ability to cope with problems without using drugs or alcohol.

Receiving support to find or move into accommodation is associated with increased likelihood of feeling safe but also reduced ability to cope with mental health problems. Other research shows that moving from homelessness to more stable accommodation can be a stressful time for people and contribute to worsening mental health.[22] Loneliness and boredom are particular challenges when moving into stable accommodation.[23] Those who are introduced to people or groups in the local community are also more likely to experience reduced homelessness and increased confidence in being in stable accommodation in six-months' time.

The regression analysis showed that **people getting support with more activities are also more likely to report improved quality of life** (as measured by ReQol score – Table A2.8). We could interpret this in different ways; it could be the support itself that helps improve people's quality of life, or it could be that people with better quality of life are more able to engage with the support on offer. The qualitative research and other evaluation evidence[24] indicates that as people's lives stabilise and their most pressing needs are addressed, they are able to better engage with other activities and support available to them.

4.3 Identifying people at risk

Key points

- In most sampled areas, potential participants are identified and referred through other services, including via multi-agency groups.
- New referral processes have been developed by areas, including processes that reduce the need for participants to repeat their stories and capture their personal goals and strengths. Northumbria is seeking to avoid the use of referral altogether.
- However, all ways of identifying potential participants require them to be in touch with other services, which could risk missing particular groups.

In our previous interim report[25] we highlighted the wide range of organisations referring participants to the Changing Futures programme. Our latest qualitative research provides further insight into the ways in which people who may pose a variety of risks to themselves and others are identified by the programme. More joined up services can help with this.

It is most common for people to be referred though other services, often ones that the programme is working in partnership with. These vary by area but include the VCSE organisations that support programme implementation and have seconded caseworkers, local authority safeguarding teams and local police. In one area, the programme team approached local organisations working with people experiencing multiple disadvantage and asked them to nominate suitable people.

Multi-agency meetings (including those pre-existing the programme) attended by caseworkers and programme staff also provide an opportunity to identify and discuss people in need of support and triage them to the most suitable service. Service delivery staff in Stoke-on-Trent reported that they attend a variety of multi-agency meetings, such as the rough sleepers meeting, women's vulnerability meeting and the Multi-agency Referral Group (MaRG). This was said to be an effective way of identifying people at risk who may benefit from receiving support from Changing Futures.

Adult Access in South Tees

In South Tees (Middlesborough and Redcar & Cleveland) referrals go to Adult Access, a multi-agency forum, which includes representation from the programme as well as professionals from other services including police, anti-social behaviour teams, housing services, and domestic abuse services. Partners discuss cases and reach a joint decision to connect the individual being referred with the right support. The team meet at 9am every day and individuals receive decisions within 72 hours. Stakeholders explained that Adult Access is aiming to create a 'one stop shop' to access. By attending the forum, the programme team are able to identify people who would most benefit from support from Changing Futures.

Most areas have professionals responsible for conducting initial assessments and deciding on an individual's suitability for the programme. **New referral processes have been developed to manage referrals into the programme in most of the sampled areas**. These include creating new multi-agency meetings and panels, such as 'introduction forums' in Stoke-on-Trent and the panel of professionals convened in Bristol, which identified 60 people that would benefit from the programme.

Hopes and strengths referral process in Surrey

As part of the Changing Futures programme in Surrey, a new referral process has been created to allocate participants to caseworkers (referred to as Bridge the Gap workers). When the programme was being set up the team decided to create an open process, which could be accessed digitally through the Healthy Surrey website, for anyone who would like to submit a referral. Elements of the process were co-produced by the lived experience network and clinical psychologist who is part of the Changing Futures team. The referral process also includes a 'Stories, Strengths and Hopes' section, which is an opportunity for service users to include information about themselves, including what they would like to achieve and also their skills, knowledge, and connections. This was introduced to limit the need for participants to repeat their story when accessing services or working with new professionals, and to promote a person-centred approach.

Referrals are reviewed by the Referral and Allocations Panel to determine eligibility. Panel members draw on their diverse professional backgrounds to check various information systems across sectors and pull together case management information, mental health history and criminal justice records. If a service user is deemed ineligible, Changing Futures staff will reach out to the referrer and signpost them to other support options. If a service user is eligible for the programme, panel members and caseworkers meet to assign service users an appropriate caseworker. During the decision-making process, service users' needs are considered alongside other issues such as gender and caseworker capacity.

In contrast, in Northumbria the programme team decided not to introduce an assessment process for participants, as people have already told their story multiple times and there was a sense that this could be harmful. Instead, **'touchpoints' within the system are used to identify people who are suitable for the programme**. The programme team spoke to a range of service providers and initially partnered with a VCSE homelessness service and a drug and alcohol service, which refers people with high-level needs. There is also now a partnership with a hospital, which refers people who attend frequently. At the time of the interview, the programme team was in the process of establishing a further two touchpoints.

Across areas, a person typically needs to present at a service, or already be known in the system, to be identified and referred to Changing Futures. **There are some concerns that people who are at risk and/or need support may not be identified or referred to the programme.** For example, in Surrey, the Lived Experience Network raised some initial concerns about the programme's open referral process, in particular, that people who do not meet certain service thresholds could fall through the gaps. in Bristol, stakeholders reported that early in the implementation there were very few referrals of young people to the programme and the programme team reported that this was because some key grassroots VCSE organisations were not aware of the programme. The programme team reached out to VCSE organisations to help increase referrals.

4.4 Challenges navigating and accessing support

Key points

- Key challenges include a lack of communication between services and siloed working; a lack of flexibility on the part of services and their staff in providing support; and some services perceiving people with multiple disadvantage as "too complex" to work with.
- Other initiatives have been working to address these issues prior to and alongside the Changing Futures programme.

Prior to Changing Futures, areas that took part in this round of qualitative research had engaged in a range of work to help people with multiple disadvantage to access support and join up services. Part of this work was facilitated through the MEAM Approach Network and Fulfilling Lives. In most areas, there were pre-existing caseworker teams in operation that supported service users to access support and encouraged services to work more collaboratively.

In addition, there are other initiatives to help join up services. For example, in South Tees the Thrive Partnership provides an integrated domestic abuse and drug and alcohol service. Similarly, Project ADDER, a national programme launched in 13 areas across the UK, operates in Middlesborough (part of the South Tees Changing Futures area) and seeks to improve communication between treatment providers and courts, prisons and hospitals.

Yet across the five areas involved in the qualitative research, there are similar and enduring challenges that the local programmes are seeking to address in relation to access and the joining up of support. Many of these challenges were recognised both locally and nationally before the programme began and have been incorporated into the programme's theory of change. Key challenges include a lack of communication between services and siloed working; a lack of flexibility on the part of services and their staff in providing support; and some services perceiving people with multiple disadvantage as "too complex" to work with. For further details, see the baseline report.

4.5 How Changing Futures areas are working to improve access to services

Key points

- Caseworkers play an important role advocating for participants to access services and providing practical assistance to overcome barriers such as lack of transportation or technology (phone, computer).
- They also provide direct support to participants, such as low-level mental health support. This includes purchasing services that participants cannot otherwise access from statutory providers, such as emergency accommodation.
- Multi-disciplinary team meetings or 'team around the person' meetings are also key ways that Changing Futures areas work to improve service access.
- Areas are developing bespoke information, research, training and learning resources to address particular local barriers to service access, such as having a history of arson.

The role of the caseworker

The **caseworker model (see page 25) is seen as fundamental to improving access to support** and joining up services. This evaluation includes a further deep dive into the role of caseworkers and a stand-alone report on the findings from focus groups with caseworkers and those who work closely with them; this is published alongside this report.

Caseworkers were reported by staff and stakeholders to have a good knowledge of the local system, available services, referral pathways, and legal entitlements as well as strong professional relationships. Many caseworkers developed their knowledge and relationships in previous roles and are also supported through a comprehensive induction process.

A big part of the role is navigating [services], we help [participants] through the system, while also supporting them alongside.

Area lead

Caseworkers help improve participants' access to services by coordinating support and advocating on their behalf. They also help to remove practical barriers, such as a lack of a phone, computer or transportation – as demonstrated by the increasing proportion of people who have received support at some time to attend appointments (see page 44).

[My caseworker] has taken me to appointments, been there to sit and listen when I need them, taken me out for food. They're there all the time.

Programme participant

Caseworkers also provide a range of support directly to participants. This helps them to manage their lives better and to feel more ready to access other services. Most commonly interviewees reported that this takes the form of emotional support, 'being there' and talking through the challenges a participant may be facing. Some caseworkers have recently been trained in mental health first aid so that they can support participants with low-level mental health problems. Caseworkers reported that they take participants out for activities such as meals, to the cinema, football matches and forest bathing.

Due to difficulties in facilitating access to some services, Changing Futures caseworkers also help to plug gaps in provision. In multiple areas, caseworkers have access to a dedicated fund that can be used for a wide variety of purchases depending on the need of the participant. This includes one off purchases, such as paying for a food shop, and longer-term interventions. For example, in Northumbria the fund has been used to provide emergency accommodation if a participant is at risk of becoming homeless and support has not been provided through statutory services. There are also examples of areas providing support that would otherwise be unavailable due to long waitlists or high eligibility thresholds. For example, the programme in Northumbria has funded bespoke trauma and mental health support through private providers and Bristol pays for essential travel.

Other activities

Caseworkers and other programme team members attend a variety of **local multi-agency meetings**. During these meetings, professionals discuss participants' needs and identify suitable support options. Caseworkers and peer specialists in Northumbria explained that they arrange multi-agency meetings around their clients when they are struggling to get the support they need.

We arrange MDTs [multi-disciplinary teams] that can draw lots of services together. We get to know the person and the services they're in contact with, such as probation, housing, adult social care, recovery services, the police and we bring them together in one meeting.

Service delivery staff, peer support specialist

In several areas, **information resources have been developed** to help Changing Futures teams and staff in wider services better understand the landscape in their area and how to access services. For example, an exercise to map referral processes for local services has been conducted in Stoke-on-Trent. Research has also been commissioned into the impact of monkey dust (a type of synthetic psychoactive drug) as its use has been a barrier for people accessing accommodation. Strategic programme staff in Surrey are in the process of formalising a directory of resources, which details service providers and routes to access.

Stoke-on-Trent and Surrey have both identified that a history of arson greatly impacts a service user's ability to access and receive support, particularly accommodation. As a result, Surrey funded a **training programme** for people with a history of fire setting, which was designed and delivered by the probation service, fire and rescue service and Portsmouth University. The training will be delivered in prisons and target people with a history of fire-setting in the hope that it will increase their housing opportunities. The programme team in Stoke-on-Trent have organised an Arson and Fire Setting **community of practice**, which has brought various services together with people who have experience of fire-setting to discuss best practice in supporting individuals with a history of arson.

4.6 How Changing Futures areas are working to join up support

Key points

- Caseworkers act as the 'glue' holding diverse services together around the participant.
- Multi-disciplinary meetings/groups provide a focus for coordinating support at both the operational and strategic levels.
- Changing Futures teams have strengthened or built new relationships with services. They are working with commissioning teams to encourage greater collaboration and have helped embed the expertise of people with lived experience into service design.

As well as enabling initial access to services, **caseworkers act as a single point of contact for services and participants throughout their support journey**. They perform this function by accompanying participants to appointments, rescheduling and cancelling appointments, completing forms, and liaising with professionals from other services. Caseworkers were described as the "glue" holding services together around the user. Caseworkers advocate on behalf of their clients to improve access to services and ensure they can continue to engage, often working as mediators, to help participants and other services understand one another's perspectives.

Again, **multi-disciplinary meetings play an important role**. In Bristol, the programme has continued to operate a My Team Around Me (MTAM), which aims to join up support by placing the client at the centre of a team of professionals who work collaboratively to support them. The aspiration is for MTAM to link in all services that support people experiencing multiple disadvantage and there are plans to engage more consistently with drug and alcohol services, housing providers, and mental health teams, where these services are not yet involved. Stoke-on-Trent have continued their Multi-agency Resolution Group (MaRG) meetings, which also brings services together around the participant. Changing Futures caseworkers are responsible for referring participants to MaRG if there have been challenges joining up services.

However, stakeholders reported that multi-agency meetings are often convened when all other avenues have been exhausted. This takes its toll on both caseworkers and participants. Holding meetings earlier could help remove system blockages in a more timely and efficient matter, improving participant outcomes.

Changing Futures staff are also tapping into multi-agency meetings to increase the focus on joining up support at the strategic level. Professionals use the meetings to build relationships and to advocate for more collaborative working. As discussed in section 4.3,

the sampled Changing Futures areas have delivered and hosted a range of conferences, forums and learning events which provide an opportunity to bring stakeholders together from across the system and reflect on ways to improve outcomes for people experiencing multiple disadvantage.

Multiple spaces in Bristol

The Changing Futures team in Bristol has created and/or maintained a range of spaces to bring together different audiences to reflect and share learning. These include The Collaborative, which was originally set up as part of the Fulfilling Lives 'Golden Key' partnership. The Collaborative acts as an 'inclusive forum open to anyone interested in the Changing Futures programme and its work with people experiencing multiple disadvantage.' A learning collective, facilitated by the programme, brings together professionals to explore different themes, such as collaboration and shared accountability. The Creative Solutions Board, made up of more senior decision-makers, explores ways to improve collaboration and find solutions for individuals who have been unable to access effective support.

The programme has also created two forums. A Black-Led Forum was launched in October 2022 by the programme's EDI lead, which brings together Black-led organisations to share knowledge and expertise around supporting people experiencing multiple disadvantage. A Grassroots Forum has also been created to share expertise and knowledge between larger and grassroots organisations. The programme recognised that due to capacity and funding challenges, many larger organisations have been unable to connect with some communities. These forums provide an opportunity for a range of stakeholders to network and share information and resources.

Sampled areas have strengthened existing relationships and developed new ones across the system. Locally, programme teams have developed partnerships with other services to join up support. For example, the programme in Surrey has partnered with an A&E department to better support frequent attenders and deliver more appropriate care. In South Tees, the programme team has developed relationships with VCSE organisations to better support people from a range of backgrounds and communities. As part of this partnership, they have explored ways to address the fact that many services only provide support for one issue, such as mental health or drug and alcohol problems, instead of considering the whole person and their needs.

In some areas, the programme team **is working with commissioners to encourage joined up commissioning** by organising meetings and workshops to increase collaboration. There are also examples of new support being commissioned, such as therapeutic provision in Stoke-on-Trent, which has been co-commissioned with public health to improve outcomes for people in supported housing with drug or alcohol problems.

The **sampled areas have helped embed people with lived experience into the design and delivery of services**. This provides opportunities for people to share challenges in relation to accessing support and joining up services. Across areas, lived experience experts have provided insight at local meetings and hosted events. In Surrey, the lived experience group has co-produced a section of a Joint Strategic Needs Assessment (JSNA), which has been dedicated to multiple disadvantage for the first time.

4.7 Impact for participants

Key points

- Participants and stakeholders reported that caseworkers are helping people to access a range of services when they need them.
- Changing Futures' persistent approach has led to participants being more willing to engage with support.
- There is evidence of services and professionals being more flexible and less risk averse when it comes to supporting Changing Futures participants.
- It is not clear whether these improvements in services are being experienced by those who are not being directly supported by Changing Futures.

The qualitative evidence indicates that programme participants are more likely to have access to the support they want and need. Caseworkers spend a long period of time developing trusting relationships with participants; they are able to identify their aspirations and create a support pathway accordingly. This includes providing or purchasing support or services that would not otherwise be available. Participants reported that this direct support is appreciated and results in improvements to their lives. In many of the examples we heard, the programme and caseworkers go above and beyond to address the challenges that participants face.

Changing Futures provided mental health support, housing, drug and alcohol support. [A peer specialist] has lived experience and got involved – she knew how I was feeling. People at Changing Futures do their job caringly.

Programme participant

Participants are more able to access additional services when they need them. Stakeholders across all areas reported that the caseworker model is helping to connect participants to services. Examples were provided where caseworkers have been able to use their professional relationships and understanding to signpost and unlock access to

services for participants. This is supported by the increase in participants reporting contact with services outside the core five (see page 43).

The Changing Futures programme is also helping to change the perceptions of participants who may have had negative previous experiences of services. Stakeholders reported that a number of participants were wary of the programme at first and questioned why the programme would be different to other support they had received. This scepticism has lessened over time.

Stakeholders from across areas shared the view that intensive support from caseworkers has increased the likelihood that a person will engage with a service over the longer term. Caseworkers often continue to work with people even after they have disengaged with other services and can help them return to the support they previously received. Caseworkers are able to hold services and professionals to account if they act in an inappropriate manner, escalating issues to senior staff as required. As a result, participants experience less friction, stigma and discrimination.

[Changing Futures] doesn't dump you and go away. A thirty-minute appointment is not enough. We all have troubles through life. In Changing Futures I'm not just a number. I'm a person.

Programme participant

There are also examples of services and professionals outside of Changing Futures becoming more flexible and less risk averse. This was due to a range of programme activities, including caseworkers advocating on behalf of participants and creating 'pressure' for professionals to provide support, as well as multi-agency meetings providing a forum to hold services to account. Stakeholders reported that professionals are less likely to say, 'this is not my responsibility' and pass on clients they view as particularly complex. It has become more common for professionals to 'take a chance' on a participant because they are being supported by the programme. There are also examples of services operating more flexibly around participants. For example, in one area, drug and alcohol services have been supported by the programme to start meeting service users where they are, instead of compelling people to travel to their office. Stakeholders also reported that adult social care is less likely to stop providing support if a service user misses an appointment. However, some services have remained 'rigid' in their approach and, for example, are unwilling to reschedule appointments if someone misses one. And while support for Changing Futures participants may be improving, many stakeholders were hesitant to say whether the situation has improved for people experiencing multiple disadvantage who are not supported by the programme.

I think that in terms of appointments that are offered, we're still seeing those appointments that are quite rigid – 'you've got to come at two o'clock on an afternoon', and that lack of flexibility. But we are chipping away at that and challenging that.

Changing Futures programme team, strategic manager

There were **some examples of more fundamental shifts in practice**. In Stoke-on-Trent, people with experience of multiple disadvantage who were referred to the adult safeguarding team often had their cases closed because they were assessed as not meeting the eligibility criteria for the Care Act 2014. As a result of the programme, professionals from the safeguarding team attend multi-agency meetings where people experiencing multiple disadvantage can be identified and appropriate support coordinated. According to professionals, there is now more consideration given to meeting the needs of people experiencing multiple disadvantage:

People with multiple disadvantage weren't really part of our cohort. We focused on can you wash and dress yourself, that type of thing, and physical disability, old age, mental health, or learning disability. Nothing in the middle. I think that's changed and the mentality of the workers is changing, and the links we have with the other agencies are changing as well.

Manager in Adult Social Care

Local challenges remain in accessing some services, within areas, typically mental health services, A&E departments, GP surgeries and housing providers. The reasons for this are explored further in chapter 5 but mainly relate to limited capacity and workforce challenges.

I'd rather work with [Changing Futures] than other services. Many others are just not bothered. They say they'll do something and never get back to you.

Programme participant

The following case study illustrates the different ways Changing Futures supports participants, bringing together and coordinating services, sharing risk and responsibility, building trust with participants and putting bespoke support in place to meet people's needs and interests.

Case study: ‘Tom’

Tom is in his early 60s, has physical illnesses and an extensive criminal record spanning decades. When Changing Futures first met Tom he was frightened because he was being exploited. He was getting beaten, and his money was being taken, but he was reluctant to move home.

The Changing Futures caseworker built a relationship with Tom and encouraged him to consider moving by reassuring him that the programme would find him somewhere he could feel safe away from the people who were harming him. The caseworker visited him regularly with the police. Slowly, trust was built until one day he agreed to move.

However, housing providers were reluctant to rehouse him due to his multiple convictions, including for arson roughly 10 years ago. The programme team identified a potential provider who offered accommodation and floating support. They were invited to the next multi-disciplinary team meeting where there was an open discussion of risk. It was made clear that risk would be shared between services and that the Changing Futures caseworker and the local police would remain involved.

The provider agreed to rehouse Tom. Within two days of moving, his whole demeanour changed. He was smiling, talking to the worker about his interest in music. The caseworker provided a variety of support to help with the transition – pots for cooking, opened a bank account for him and found him somewhere to listen to music. To help Tom feel safe, an intercom has been fitted to his door so he can see who is there and can control who he lets in. None of his old acquaintances have come to find him. The move has made a dramatic difference to other aspects of Tom’s life. He is now engaging with drug and alcohol services, and although he is still using substances, it is said to be minimal.

4.8 Impact for services and the wider system

Key points

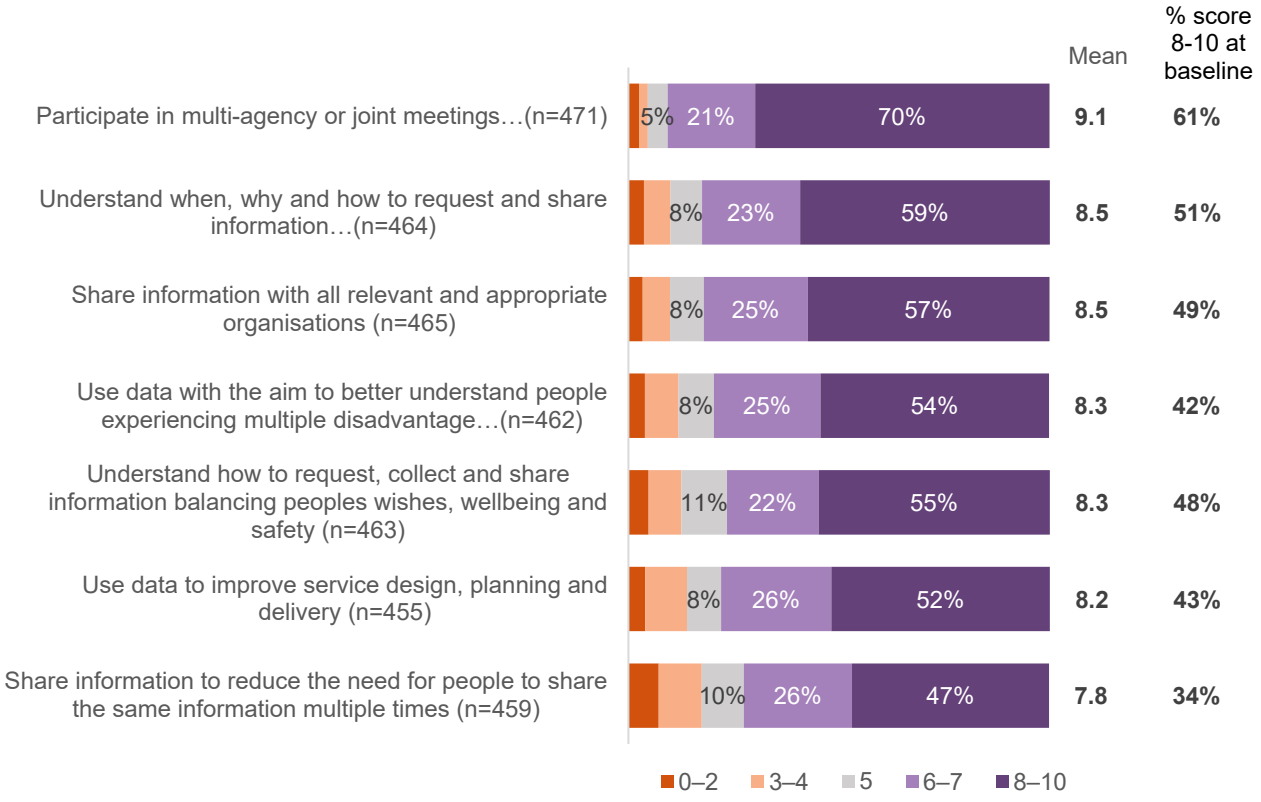
- Services and staff appear to be communicating better and sharing information about service users more frequently.
- There is evidence that professionals (both within and external to Changing Futures teams) have a better understanding of what support is available across the local system and how to access it. Linked to this, there are examples of reducing duplication of effort.
- Despite improved information flows and coordination, progress towards improved access to services is variable.
- Changing Futures caseworkers have helped encourage flexibility in the system, but there are concerns that changes seen to date will not be sustained beyond the end of the programme.

The programme has increased communication between various services and professionals, promoting more efficient and effective working relationships locally. This has been achieved as a result of the programme activities outlined in sections 4.4 and 4.6. Stakeholders reported that professionals work together more closely to provide support, discuss challenges and seek resolutions.

In both interviews and the follow-up partners survey, stakeholders reported that **services are frequently sharing information about service users**. In the partners survey, which had roughly equivalent numbers of statutory and voluntary sector respondents, 82 per cent (n=465) reported that their organisations share information about people experiencing multiple disadvantage frequently (a mean score of 8.49 on a scale of 1-10 where 0=never and 10=always).

Multi-agency meetings have been particularly helpful for identifying which service is best placed to deliver support and monitoring participant engagement. 91 per cent of respondents reported that their organisation participates in such meetings to share information about or plan support for people experiencing multiple disadvantage frequently (see Figure 4.5).

Figure 4.5: On a scale of 0-10, to what extent does your organisation do the following…



There is also evidence that this data sharing is, to some extent, systematic rather than ad hoc. In the follow-up partners survey, 57.7 per cent of respondents (n=489, see Table A3.3) reported that their organisation shared client records, data management or information systems with other organisations involved in the local system. A similar proportion of respondents (55 per cent) reported this in the baseline survey.

Services work together now, and they work around me… people would previously bypass me and talk about me behind my back.

Programme participant

In some Changing Future areas, however, it remains challenging to engage and share information with some organisations. For example, interviewees said it is common to experience difficulties accessing information about participants from statutory services, as some services remain cautious about what information they share. On average, voluntary sector respondents were more likely to report that their organisations share information about people experiencing multiple disadvantage than statutory sector respondents (means of 8.0 and 7.0 respectively, on a scale of 1-10 where 0=never and 10=always). Similarly, voluntary sector respondents were more likely to report sharing information in

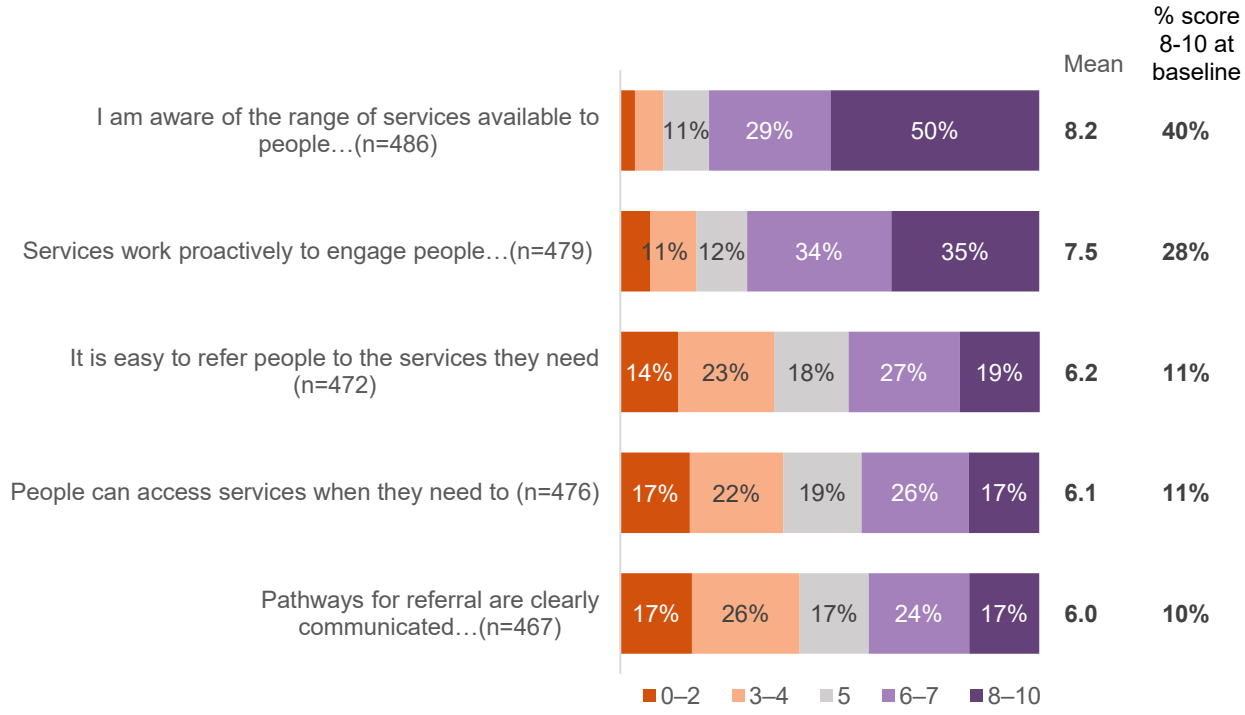
ways that reduce the need for people to share the same information multiple times than the statutory sector (means of 7.3 and 6.3 respectively.) However, respondents from both sectors identified factors that slow progress towards better information sharing. These included the impact of GDPR, competition for resources, technical barriers such as myriad data systems, and services engaging in firefighting.

The convening power of the Changing Futures partnership is very strong. The limitation is the resources within each organisation. The NHS, where I work, is under immense pressure and is therefore reactive, more so than I ever remember in my 30-year long career. This makes communication with other agencies very difficult to prioritise. It is imperative that the Changing Futures partnership role is recognised, because without it, there would be no collaboration whatsoever.

Survey respondent

The follow-up partners survey also provides some evidence that most **professionals have a strong understanding of their local system and what support is available.** For example, 79 per cent of respondents (n=486, mean=8.2) tended to agree that they were aware of the range of services in their area available to people experiencing multiple disadvantage, with 50 per cent strongly agreeing. For comparison, 73 per cent (n=468, mean=6.7) tended to agree in the baseline survey.

Figure 4.6: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?



Interviewees also reported that **activities to join up support have reduced duplication across the system**, as services are more aware of the support that is being provided. For example, in Stoke-on-Trent stakeholders reported that the Introduction Forums, where all referrals are reviewed collectively, enable professionals to communicate about the support they will be providing.

…it also eliminates duplication as well, so I was noticing that we'd got housing that were doing a very similar thing to public health, but different outcomes, but wanting to have the same impact, so we've been able to narrow that down a little bit as well.

Strategic stakeholder, multiple disadvantage

However, **despite high awareness of the services available, challenges persist in relation to accessing services**. As seen in Figure 4.6, timely access to support for people experiencing multiple disadvantage remains an issue: only 43 per cent (n=476, mean=6.06) tended to agree that people experiencing multiple disadvantage can access services when they need to.

Both interviewees and survey respondents described services continuing to operate with high thresholds, inflexible policies, or siloed cultures. Only 46 per cent (n=472) of stakeholders tended to agree that it was easy to refer people experiencing multiple

disadvantage to the services they need, and only 41 per cent (n=467) tended to agree that referral pathways were clearly communicated to people experiencing multiple disadvantage.

A number of responses to open survey questions suggested that resource pressures are contributing to a lack of progress in these areas:

Long waiting lists and last-minute support for mental health. You have to be in a critical situation for housing. The staff are amazing [they] just don't have resources to provide the services timely enough for individuals.

Survey respondent

Survey respondents also noted that progress varied across their local systems, including between teams and organisations, different geographic areas within the local system, and different service sectors; several respondents mentioned that health, drug and alcohol and housing services work less flexibly.

There were some positive indications that services are beginning to respond to the programme's ambitions. For example, in Bristol stakeholders reported that the work of the Creative Solutions Board is starting to 'pay off', as members from other services are now considering and implementing creative solutions themselves. Despite continuing difficulties with access and referral, a relatively high proportion of stakeholders (69 per cent, n=479) tended to agree that services were working proactively to engage people experiencing multiple disadvantage.

One explanation for this mixed picture may be that although the Changing Futures programme has introduced some flexibility in local systems, this requires dedicated professionals, working tirelessly to communicate and negotiate with services on behalf of participants. Many of the positive impacts experienced by participants relate to specific and ongoing programme activity, most commonly, the caseworker model.

The main challenge identified by stakeholders is the programme's ability to influence the wider system in a sustainable way. A number of caseworkers and programme staff expressed concern that people with experience of multiple disadvantage or complex needs who are not supported by Changing Futures are likely to continue to face challenges accessing and navigating support, and that if the programme ends, much of the progress made in these areas is likely to be reversed. There was a sense that services will go 'the extra mile' for participants of Changing Futures because there is a caseworker and programme team advocating on their behalf and, in some cases, applying pressure on professionals to adapt their approach. There was concern that without these roles, this would not happen.

I think there's still a lot that needs to be done to join up services supporting people experiencing multiple disadvantage. The service group my team falls under focuses on supporting individuals experiencing multiple disadvantage, however we use something like 4 or 5 separate data systems and don't always work together in a cohesive manner.

Survey respondent

5 Challenges and enablers

This chapter draws together the key challenges and related enablers reported by local areas to embedding trauma-informed practice, improving access to and joining up services. In addition to those specifically related to the set up and running of the Changing Futures programme, there are factors in the wider system that affect the impact of programme activities. We draw exclusively on interviews with sampled areas for this part of the report. However, many of the challenges are not new and are well documented elsewhere in the literature.

5.1 Challenges for effective delivery of Changing Futures activities

Key points

- It takes time to build relationships with participants; imposing time limits on supporting people may be unhelpful.
- Caseworker flexibility is key to the Changing Futures model, but there are limits to this. There is a need to agree what 'flexible' means in practice. Balancing flexibility with managing risk can sometimes be difficult.
- As the programme has grown, caseworker and other programme staff capacity has become strained in some instances.
- Building understanding of the programme has taken time and a considerable amount of work, which has sometimes created tensions between this and delivery.

It takes time to build relationships between caseworkers and participants. This is in part due to the complexity of the issues faced by participants, which take time to understand, as well as the impact of previous negative experiences of services. It can take multiple meetings with their caseworker before participants are prepared to work with them and engage with support. Sampled areas have different timelines for working with participants; some Changing Futures caseworkers continue working with clients across the lifespan of the programme, whereas others have set time limits.

There are limits to caseworker flexibility. Across areas, stakeholders emphasised the importance of taking a flexible and person-centred approach. However, this can sometimes be difficult. There may be meetings, appointments or training that a caseworker is expected to attend, and it is not always possible to provide support when a participant wants it. It is unrealistic to expect caseworkers to provide around the clock support. What

support is available and when needs to be negotiated. There is a need to agree what 'being flexible' means within this context.

Caseworkers can find it difficult to manage risk while taking a trauma-informed approach. Despite the limitations outlined above, the Changing Futures caseworker model is generally seen as more flexible than other services. However, this requires professionals to use their discretion and weigh up risks on a regular basis. They must balance the need to build trusting relationships with participants with the need to involve others in managing risk, for example, in the case of safeguarding concerns or the disclosure of criminal activity. Interviewees highlighted that there can be tensions between the principles of trauma-informed practice, such as choice and safety. For example, one caseworker spoke about supporting a participant to recognise when people they associated with and allowed into their home might not be genuine friends. Rather than managing the risk of exploitation by banning people from the property or sanctioning the tenant, the caseworker and the participant worked out together how to balance the desire to have friends and socialise with the risks of placing trust in the wrong people.

Tackling barriers on others' behalf can be emotionally draining. Several caseworkers described the negative impact on them of navigating inflexible services and constantly working to overcome barriers experienced by their clients. Some caseworkers with lived experience explained how hitting roadblocks and repeating participant stories can be re-traumatising for them.

As the programme has progressed, need has begun to exceed service capacity. This has meant that delivery staff have sometimes been unable to get supervision when they wanted it and have not always been available to provide support with addressing system barriers. In two of the sampled areas, capacity of caseworkers was raised as a particular challenge. The number of referrals to Changing Futures has increased as awareness of the programme has grown This has resulted in waiting lists in some areas and higher caseloads in others. The caseworker model is most effective when caseworkers have small caseloads and provide intensive support to participants. As a result, only a small number of people can be supported at one time, and this presents a challenge.

Some stakeholders reported challenges at the start of the programme in raising awareness of Changing Futures and getting people to understand its purpose. This made it more difficult to improve access and join up support. There were instances where statutory services ended support for participants because they thought the caseworker was taking over this. Building understanding of the programme has taken time and a considerable amount of work, which has sometimes created tensions between this and delivery, especially at the front line.

5.2 Challenges within the wider system

Key points

- Capacity and staff challenges within core services make it difficult for participants to get the flexible support they want. Staff turnover also makes embedding trauma-informed working more challenging.
- For similar reasons, it can be difficult to engage some services in training and/or multi-disciplinary meetings.
- Some services are risk averse and reluctant to support people experiencing multiple disadvantage. People continue to be stigmatized and branded as undeserving or difficult.
- Multiple disadvantage is just one of a number of competing priorities and initiatives taking place in local areas.

Across many of the services that people experiencing multiple disadvantage use, there are staffing and capacity challenges which are well-documented, including in our previous interim report. These frequently result in participants being placed on lengthy waiting lists for services, and when accepted for support, it is often time-bound with short appointments. Within this context, it is challenging for participants and professionals to build meaningful relationships and for professionals to understand participants' situations, thus reducing their ability to provide a tailored support offer. It is also difficult to empower participants and give them control over their care. The principles of a trauma-informed approach can be difficult to implement when services are under high levels of pressure and have limited capacity, and professionals also have limited time to connect with other services and improve joined up working.

The doctors are a joke. It's all still over the phone and you have to phone them at 8am. Some of it's now online and you have to fill in loads of forms and answer different questions. Some doctors are understanding, and some not.

Programme participant

Interviewees gave a number of examples of occasions where the most appropriate support for a participant was unavailable. Stakeholders across all sampled areas raised the issue of limited accommodation options; this was also mentioned in our previous interim report. Housing services are often unable to provide people with the accommodation that they want. For example, one stakeholder explained that there have been instances where women have been placed in accommodation with men, even though this goes against their wishes and made them feel unsafe.

Many statutory services have recently experienced high attrition rates within their workforce. This has resulted in a flow of new staff entering the system who may not be trained in the principles of trauma-informed care and can result in established relationships being lost. Both stakeholders and participants reported that it can be challenging to have to start afresh with a new professional and retell their story.

Participants identified services that they had previously had issues engaging with. Although caseworkers advocate for clients, **some services remain difficult to work with due to a lack of flexibility**, which is often related to high levels of demand and limited capacity. It remains common for some services to have rules and processes that are inflexible and do not support a trauma-informed approach. For example, many mental health services close a client's case if they miss three appointments, and some housing providers stop providing accommodation for people if they go into someone else's room in a supported setting or use substances. As one stakeholder commented, it is important that services consider the reasons why a person may miss an appointment or disengage.

[For] clients with multiple disadvantage, in-person appointments are the last thing on their priority lists.

Strategic stakeholder, multiple disadvantage

Some services remain difficult to engage in training and multi-disciplinary meetings, partly due to limited staff capacity and resources**.** Most commonly these are mental health services and housing, although in one area, attendance from health professionals was also limited. Notably, these are also the service areas where the programme appears to be doing most 'gap filling' (see page 52). Lack of attendance is a barrier to embedding trauma-informed practice and limits the programme's ability to improve access and join up support. The impact of multi-disciplinary meetings is dependent on the professionals that attend and there have been examples where certain professionals have not engaged, even when the service is an important component of a participant's support.

Within some services, people experiencing multiple disadvantage continue to be stigmatised, discriminated against, and branded 'undeserving' or 'difficult'. Caseworkers and participants provided a number of examples of this. Caseworkers reported that by navigating services alongside participants, they have seen firsthand the negative treatment service users receive from providers. One caseworker shared that professionals often change their approach once they see the caseworker's lanyard. In circumstances where professionals are rude and dismissive, participants are, unsurprisingly, less likely to engage. Though negative attitudes towards people with multiple disadvantage are found everywhere, adult social care, mental health services, DWP and jobcentres were mentioned frequently in this regard.

Some services operate risk-averse practices. Some professionals from statutory services are concerned about the consequences of making a decision that may lead to a

negative outcome. Risk can, therefore, act as a barrier to participants accessing the support they may need. For example, stakeholders said that it can be very difficult to house people with experience of multiple disadvantage if they have histories of substance use or criminal behaviour. Housing providers have to weigh up the risk of someone being homeless alongside the risk an individual may pose to the people that are already being supported. Examples of ways in which Changing Futures areas have been addressing these issues are provided in section 4.4 on page 53.

Many of the local systems sampled in this round of qualitative research do not have access to a shared data platform. This makes it challenging for professionals from different services to quickly understand a service user's journey and the support that they are receiving. One area attempted to establish a shared case management system as part of the programme. However, it did not receive the appropriate level of support from some senior stakeholders and so progress has been limited. At the time of interview, stakeholders reported that the local authority is talking about introducing a new system, which is acting as a disincentive to services joining existing systems.

Changing Futures is part of a much bigger system, with lots of competing priorities. Programmes and initiatives introduced to a local area to galvanise systems change are competing with other system and service priorities and existing pressures. For example, in one area a local authority is undergoing a structural reorganisation, which has implications for the workforce and how funding is allocated. This has created uncertainty about where the programme will be positioned within the council and confusion when recruiting for new roles. Similarly, stakeholders from Changing Futures areas that cover a large geographical region reported practical challenges, such as difficulties getting participants to certain services due to travel logistics and cost.

5.3 Enabling factors for effective programme delivery

Key points

- Alignment of the aims of Changing Futures with other services' goals helps build support.
- Working within a diverse team of professionals from a range of backgrounds is beneficial for sharing knowledge, in particular on navigating data systems.
- Embedding the team within a well-connected and credible host organisation can also generate buy-in to the programme.
- Supportive senior managers can help unblock system problems for caseworkers.

The programme aligns with wider system goals in many areas (for example, reducing rough sleeping; preventing unplanned hospital admissions and visits to A&E; reducing

anti-social behaviour; improving population wellbeing) and has therefore been able to support other services. By acting as champions for others' goals, the programme team is able to get partners to be receptive to their work.

Stakeholders reported that **a participant having a caseworker can often improve access to services.** Professionals view the caseworker as a way of minimising risk, as they know participants are receiving intensive support. The role and impact of the caseworker has been highlighted throughout this report.

Stakeholders find it beneficial to work within a diverse team, including people from different backgrounds and with different professional experience. In one area, stakeholders reported that having a diverse mix of staff has improved their understanding of different data systems. For example, recruiting a senior social worker with access to the local prison's data systems saved time across the team. Similarly, in another area, members of the Changing Futures team struggled to access medical histories for participants from the NHS; the clinical psychologist was able to show them how to navigate the NHS system and retrieve information.

Caseworkers spoke of leveraging their personal relationships with professionals across the system and the 'clout' that they have through the Changing Futures programme. Often these relationships existed prior to Changing Futures, developed through previous programmes such as the MEAM Approach and Fulfilling Lives.

Embedding the programme in a well-connected and credible host organisation, such as the local authority or a VCSE organisation, can help to generate buy-in from other professionals across the system. Interviewees felt that there were advantages to both, but that local authorities in particular could leverage buy-in:

Embedding Changing Futures into the local authority has definitely helped the programme receive more support from senior leaders and internal departments - local authority staff and departments have been directly involved from the beginning and that's made a big difference.

Senior stakeholder

Across areas, stakeholders emphasised the importance and benefit of having supportive senior managers. Caseworkers said that it helps them to feel as though they have 'back up' during tricky situations, and they can rely on managers to help them galvanise other services and professionals when they encounter blockages within the system. In one area, caseworkers and peer specialists said that this has been an effective enabler for participants too, as previously the support professionals could offer would be limited by the decisions made by other services.

5.4 Enablers within the wider system

Key points

- Forerunner programmes and earlier work on multiple disadvantage in some areas has helped to build understanding and establish programme credibility.
- Growing interest in and awareness of the importance of trauma-informed working has also helped enhance Changing Futures work in this area.
- Where shared data systems exist, they support better understanding of participants and reduce time spent on sharing information.
- Understanding the local system and meeting key contacts is easier in smaller geographies.

Professionals and services have 'bought into' Changing Futures. Across areas, stakeholders were able to identify services and professionals who are supportive of the programme and want to improve access and join up services. This was noticeable in areas where previous programmes, such as the MEAM Approach and Fulfilling Lives, had stimulated conversations and progressed similar aspirations. These programmes have also established a degree of credibility for Changing Futures which helps programme staff to develop relationships. In the areas included in this round of qualitative fieldwork, probation and DWP staff were working closely with Changing Futures teams, while some areas reported that mental health services remained harder to engage.

Many of the professionals recruited as part of Changing Futures have a strong understanding of their local system and professional relationships which they have used to get buy-in to activities and training opportunities. Additionally, some areas have been able to partner with well-established organisations as part of their work, which has given them credibility with others. For example, in Stoke-on-Trent, the INSIGHTS Academy is run by Expert Citizens, who are well known locally and have previously provided trauma-informed training. Members of the programme team have been able to use existing momentum to hit the ground running.

The most commonly mentioned enabler across the wider system was an increased recognition of the importance of being trauma informed. Before Changing Futures, many professionals had already heard of the principles, received training on the subject, and/or started to move toward working in a trauma-informed way. This meant that many services and professionals were receptive to activities to improve trauma-informed working, and the team was able to build strong working relationships with professionals across the system.

In areas where services do have shared data systems, they have enabled a better understating of a service users' journey and resulted in less time being spent sharing a participant's story. For example, in Stoke-on-Trent, the Changing Futures team and the other non-statutory services they are co-located with are able to access the council adult social care team's customer relationship management and data systems. While stakeholders acknowledge that the system is not perfect, it enables services to see the same information about people and reduces the need for service users to continually repeat themselves. This is a widely acknowledged enabler for improving system working and was explored in detail in our previous interim report.

Just as larger and more complex geographies can present challenges, **improving access to and joining up services can be easier in smaller geographical areas,** such as Stoke-on-Trent. This is said to be because 'everyone knows each other'. This was also reported in an earlier round of qualitative research when speaking to stakeholders from Plymouth. Stakeholders in Stoke-on-Trent reported that meetings and local events are often attended by most agencies, which means faces quickly become familiar. As a result, it is easier to know who to contact and to navigate the system as a whole.

6 Conclusions and recommendations

6.1 Individual outcomes

The evaluation adopts a theory-based and largely qualitative approach to explaining outcomes observed during the programme at the individual, service and systems level. Complex systems such as this can be challenging to evaluate and establish causality. The evaluation overall includes the use of a theory of change, systems mapping, participatory approaches, and the triangulation of qualitative and quantitative data to help understand how the different elements of the systems interact and to identify key mechanisms of change. However, it is difficult to establish the extent to which factors external to the programme are also having an effect on outcomes.

Overall, **the evidence indicates that Changing Futures participants are gradually making progress towards healthier, safer, more stable and fulfilled lives.** There are small but significant changes on many of the key outcome measures, including reduced rough sleeping, domestic abuse, ambulance callouts and A&E attendances. Participants also report improved financial stability (such as increased ability to manage debt), mental wellbeing and social connectedness. Fewer people have no-one to talk to apart from their support workers. Where there appears to be little overall change, this is often because some participants are reporting improvements in their situation and wellbeing while others are reporting a worsening of these things.

Changes in ability to cope without drugs and alcohol illustrates this point well. While some participants report positive progress, a substantial proportion are still unable to cope after roughly five to nine months. This serves to underline the difficulties of overcoming addiction, particularly for people experiencing other forms of disadvantage. Change is likely to be slow[26], and at present, we are generally only able to examine change over the first year of people's time with Changing Futures.

The programme participants who shared their experiences with us for this and previous reports are overwhelmingly positive about the support they are getting from Changing Futures. They highlight the ways their experience of the programme is different from other services; staff have time, listen to them and follow through on promises. In particular, the programme continues to support people through relapses and more challenging times. However, the programme aims to have a long-term impact on the lives of participants, many of whom are likely to need ongoing support beyond the life of the programme. So far, **we have found limited evidence that the system will be able to maintain improvements in participants' experience of support and engagement after the programme ends**, as many of the outcomes relate to the support provided by the Changing Futures caseworker model.

Evidence from a variety of sources – quantitative and qualitative – highlights the importance of people being supported to attend appointments, whether that is physically accompanying them to provide support, reminding them to attend or helping them to access transport. In a system (see below) that is often inflexible in terms of the demands it places on service users, and where there is the threat of cases being closed for non-attendance, support to attend is vital in maintaining access and engagement.

Providing this type of support requires caseworkers to have low caseloads. Small caseloads are also vital for building relationships with people experiencing the most entrenched forms of disadvantage (as targeted by Changing Futures) and for providing flexible and tailored support; it is sometimes necessary for caseworkers to spend a full day with the same person. All Changing Futures areas have relatively low caseloads compared to less intensive forms of case management.[27] However, we are still able to detect a positive link between lower caseload sizes and the likelihood of improvements in levels of participant need and risk (as measured by the NDTA). The importance of small caseloads is also supported by the evaluation of the Fulfilling Lives programme, which indicated caseloads of between six and ten when working with this client group.[28]

Charting patterns of participant engagement with core services, we see notable increases in new participants having at least some contact with services early on in their journey with Changing Futures. But people do not necessarily appear to be maintaining new contact with services on an ongoing basis. This is arguably a particular issue when it comes to drug and alcohol services given how long recovery is likely to take. In contrast, contact with homelessness services ideally should be brief. There is a steep increase in new people having contact with homelessness services in the first five months or so on the programme. But this does not appear to result in sustained reductions in homelessness (although, as set out above, rough sleeping specifically is reducing).

A lack of sustained contact with core services also highlights the importance of the additional support that Changing Futures teams are providing or facilitating, whether this be housing or therapeutic activities. It is notable that contact with mental health services is the only core service in our regression analysis that is associated with some positive outcomes. And yet the qualitative research indicates this remains particularly challenging for participants to access.

Despite differences in their approaches to finding people who would benefit from support from Changing Futures, identification of potential participants in all of the sampled areas requires participants to be in touch with service providers. While it is positive that the programme is receiving referrals from a broad range of services, there is some concern that this could mean people are being missed.

6.2 Service and systems level outcomes

Changing Futures areas are seeking to encourage trauma-informed practice in wider services by modelling trauma-informed working, dedicating roles to promoting trauma-informed practice and providing training and other resources to local services. At the same time, Changing Futures has sought to encourage trauma-informed design by working with commissioners and helping to embed lived experience into service design. **There is evidence of increased awareness and understanding of trauma-informed practice, and of progress towards more trauma-informed services, with stakeholders reporting trauma-informed behaviours.** However, evidence on the extent of change in practices is mixed, with some stakeholders expressing doubts about the degree of trauma-informed working outside of the services funded by the programme. In addition, stakeholders describe how resource pressures can prevent moves towards more trauma-informed practice.

Though the programme is working to improve access to services generally, it is also providing (though skilled caseworkers) or purchasing (using personal budgets) essential services and support that are not otherwise available. **There remain substantial barriers to people gaining access to essential support such as accommodation and treatment from specialist and clinical services.**

We found some notable differences between the voluntary and community and statutory sectors. Information sharing and adoption of trauma-informed practice appears to be more likely within the voluntary and community sector. Statutory sectors are more often characterised as risk averse and inflexible. Conversely, some participants report that being part of a statutory organisation brings with it more credibility and influence with other professionals.

Caseworkers are helping to navigate and connect services and ensure participants can engage with them. However, improvements to the referral processes for and access to specialist services outside the programme are limited, with stakeholders continuing to report issues such as high eligibility thresholds, and inflexibility within some services. There are some innovative activities underway in Changing Futures areas to enhance access to services – including the expanded use of multi-agency meetings to plan support, and Northumbria's innovative 'no-referral' approach. However, much activity is focussed on developing more effective ways to navigate the complex system, rather than making access to services easier.

Systems change is a slow process that requires time to build the necessary relationships and structures. Those areas that had benefited from programmes such as Fulfilling Lives are, in some respects, in a stronger position to make progress on key Changing Futures aims. For example, the work to develop an understanding of different partners and the caseworker model had already been undertaken.

6.3 Recommendations for Changing Futures

Continue to prioritise building collective responsibility. Some stakeholders felt that other services might become dependent on the support provided by the Changing Futures programme. It is therefore important that the programme continues to focus on building collective responsibility across other organisations to ensure they recognise that they also have a role to play and accountability for service user outcomes is shared.

Focus on support coordination earlier in the participant journey where possible. The evidence in this report highlights the value of multi-agency meetings for resolving issues. However, stakeholders report that these are often convened when all other avenues have been explored. Similar meetings to coordinate support for participants earlier in the journey could help remove system blockages and improve outcomes in a more timely and efficient manner.

Future research and evaluation should seek to build on the programme's work addressing barriers to accessing services and service thresholds. Capturing the learning from new approaches to referral, including the further development of the role of multi-agency meetings and alternatives to traditional referral processes, would be of value. This could support discussions around improving referral pathways in local areas, just as the programme's learning on trauma-informed practice has helped raise awareness among local system stakeholders.

Changing Futures strategic leaders should continue to prioritise engagement with health and housing commissioners including Integrated Care Systems. Progress for participants continues to be largely due to the activity of Changing Futures caseworkers rather than changes in the accessibility of services and eligibility criteria, although some new services and new support for trauma-informed working have been commissioned.

6.4 Implications for policy beyond the Changing Futures programme

Changing Futures (along with parallel and predecessor programmes) are playing a vital role in coordinating support, convening multi-disciplinary meetings and providing opportunities for learning. This role is valued by other services, but they often lack the capacity to undertake it themselves. It is unlikely such coordination will continue beyond Changing Futures without a similar dedicated function. **Consideration is needed as to how the support coordination role currently fulfilled by Changing Futures could be mainstreamed.**

The effective engagement with participants and positive impact on other professionals and services achieved by Changing Futures caseworkers is only possible because of the low caseloads and high-quality support they are receiving. However, caseworkers in some

areas describe rising demands on them, including additional burdens imposed when navigating inflexible services. **It is necessary to consider how the low caseloads and consistent support provided by Changing Futures could be sustained.**

Workforce turnover across local systems has impacted on efforts to embed trauma-informed practice through the Changing Futures programme. In environments with churn, **permanent sources of support for staff at all levels in trauma-informed approaches would help to sustain progress made to date**. Trauma-informed support for senior staff across sectors would help to sustain strategic buy-in at a local system level. As part of this**,** ongoing access to guidance and support for those leading local workforce development strategic planning would be beneficial. Engaging with further and higher education providers could help to ensure trauma-informed practice is embedded within health and social care professional training.

The experience of Changing Futures highlights the multiple barriers to local areas achieving common data systems and resources. It also demonstrates the benefits to services and people experiencing multiple disadvantage when these systems are in place. **It is important that learning on data sharing is available to those undertaking work in different sectors**, including health and local government, to support and foster better data sharing capabilities in local areas.

A number of stakeholders referenced the mismatch between the scale of need and the resources available through Changing Futures. **Areas need better information on local needs in relation to multiple disadvantage, including the scale and nature of need and how this varies for different groups.** Joint Strategic Needs Assessments (JSNAs), which set out the current and future health and social care needs of a local area offer one opportunity for this, as local areas are free to define the scope and format of these assessments. For example, in Nottingham, the JSNA forms part of its consideration of the wider determinants of health, including a separate chapter on multiple disadvantage.

Appendix 1: Additional methodological detail

Evaluation in a complex system and challenges of attributing impact

The programme aims to make an impact at the individual, service and systems levels. All of these levels are systems in themselves that also interrelate, and we will not be able to examine the complex interrelationship of all outcomes and levels. Furthermore, there are a number of other government funding programmes running at the same time as Changing Futures and working with the same cohort in many of the same areas. These include the Rough Sleeping Drug and Alcohol Treatment Grant, Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery) and mental health transformation funding. Complex systems can be challenging to evaluate. Not only is proving causality difficult, but complex systems can also be particularly sensitive to context and vulnerable to disruption.

The evaluation takes a theory-based approach, and methods include the use of a theory of change, systems mapping, participatory approaches, and the triangulation of qualitative and quantitative data to help understand how the different elements of the systems interact and to identify key mechanisms of change. This is in line with HMT's Magenta Book, which states that theory-based evaluations are suited to situations in which there is a complex policy landscape or system. Regular reporting will ensure that emerging process findings can feed into the ongoing development of the programme.

As part of MHCLG's aim to provide evidence of the impact of the programme on individuals experiencing multiple disadvantage, we were asked to assess the feasibility of conducting a robust impact evaluation using a suitable comparison group. A separate report explores this work in detail[29], but it was concluded that progressing a comparator study would not be an efficient use of resource and would be unlikely to provide a robust impact evaluation. MHCLG is currently exploring options for administrative data linking to understand trends in engagement with the criminal justice system for participants both prior to and after engaging with the Changing Futures programme. This could include identifying a matched counterfactual group within the data. While this work will not be able to provide a full assessment of programme impact given it is focused on only one outcome domain, it will provide an important mechanism for assessing change in this area, particularly if changes in participant outcomes can be compared to a counterfactual group.

Quantitative data and analysis

Table A1.1 describes the different quantitative data collected by funded areas, the frequency of collection, and who provides the information.

Table A1.1: Quantitative data sources and frequency and method of collection

Source	Type of data	First completed	Updated	Completed by
Outcomes questionnaire	Outcomes since joining the programme, and experiences in the previous 3 months (could be before joining)	Within 6 weeks of joining the programme	Quarterly	Participant (can be with support from worker)
Historical questionnaire	Participants' characteristics and their experience of disadvantage	Within 12 weeks of joining the programme	One-off questionnaire	Participant (can be with support from worker)
New Directions Team Assessment (NDTA)	Assessment of participants' levels of need, risk, and engagement with services	Within 6 weeks of joining the programme	Quarterly	Support worker
Service-held outcomes data	Participants' engagement dates, referrals to other services, and outcomes of referrals since the start of the programme	First 3 months of the programme (January to March 2022)	Quarterly	Programme staff
Operational data	Details of delivery of direct support to participants, such as caseload sizes and staff absences	First 3 months of the programme (January to March 2022)	Quarterly	Programme staff

This report mainly draws on data from the first three rounds of outcomes questionnaires and NDTA: baseline, first follow-up, and second follow-up questionnaires.

Gathering data from people experiencing multiple disadvantage can be challenging. Previous evaluations in this field[30] highlight the importance of trusting relationships for both providing support and collecting data. We want people to feel comfortable about telling us about themselves and their experiences. Therefore, it was decided that quantitative data

would be collected from participants by support staff who have a relationship with them (rather than by professional research staff).
Funded areas are encouraged to adopt a trauma-informed approach to completing questionnaires with people, therefore, not all have been undertaken within the desired timeframes set out in Table A1.1. However, in order to maximise the sample available for analysis we have taken a pragmatic approach and only excluded those questionnaires completed substantially outside expected timeframes – Table A1.2 sets out the completion timeframes for questionnaires included in this analysis.

Table A1.2: Parameters for including questionnaires in the analysis

Outcomes questionnaire	Include questionnaires completed within…	Mean completion date after start of included questionnaires
Baseline	-60[§§] and 180 days of programme start date	60 days
First follow-up	30 to 300 days of programme start date	147 days
Second follow-up	120 to 420 days of programme start date	242 days
Third follow-up	210 to 540 days of programme start date	322 days (infrequently used due to small number of responses)

As of August 2023, we had received 1,569 completed baseline questionnaires. 1,436 of these (91.5 per cent) were completed within the timescales above. 962 baseline NDTAs (65 per cent) were completed with the timeframes. 1,362 participants had completed a historical questionnaire.

As we have included participants' baseline questionnaires completed up to six months after their programme start date in our analysis, their circumstances may have changed in the period between joining the programme and providing baseline data. Such could affect the accuracy of the baseline picture and, thus, the extent to which change in some measures is fully captured.

The quantitative data are dominated by a small number of Changing Futures areas. Over half (65.2 per cent) of participants represented in baseline outcomes questionnaire data come from three areas: Greater Manchester, Lancashire, and South Tees, with nearly one third of participants coming from Lancashire alone. However, this is broadly representative of the distribution of participants among areas — see Table A1.3.

[§§] from the programme.

Table A1.3: Baseline outcomes questionnaires completed in comparison to overall participant numbers by funded area

Area	Participants completed baseline outcomes questionnaire data (percent)	Participants reported to DLUHC – October 2023 (percent)
Bristol	2.6	1.8
Essex	6.6	4.3
Greater Manchester	17.5	11.6
Hull	1.3	2.5
Lancashire	32.9	31.0
Leicester	3.8	2.7
Northumbria	0.3	0.8
Nottingham	4.4	5.5
Sheffield	5.4	2.3
South Tees	14.8	16.0
Stoke-on-Trent	3.6	9.4
Surrey	4.1	2.0
Sussex	0.3	6.0
Westminster	2.4	4.0
Total	**1,436**	**3,581**

Outcomes and historical questionnaires were designed to incorporate trauma-informed principles. Questions were tested with people with lived experience of multiple disadvantage and feedback provided by service delivery staff. No questions are mandatory, with the option for beneficiaries to select ‘Don’t want to say’ throughout. Factual questions can be populated using staff knowledge to reduce the need for people to repeat their stories multiple times. To support learning and quality assurance, open text boxes are provided for staff to give further detail as to why questionnaires could not be completed with the participant. Training was delivered to staff on conducting trauma-informed research at the start of the evaluation, with refresher training on data collection provided in November and December 2023.

We have excluded from our analysis questions that ask for value judgements or assessments of emotion that have been completed without input from the participant. Roughly a quarter of baseline and first follow-up outcomes questionnaires were completed without input from the participant (24.6 and 23.4 per cent respectively). For the second

follow-up questionnaire, 20.6 per cent were completed without participant input (see Tables A1.4, A1.5 and A1.6)

Table A1.4: Baseline outcomes questionnaire: How was this questionnaire completed?

Completion approach	Frequency	Percent
Entirely with the beneficiary	534	34.0
Partially with the beneficiary, partially using existing staff knowledge	649	41.4
No response available from the beneficiary	386	24.6
Total	**1,569**	**100**

Table A1.5: First follow-up outcomes questionnaire: How was this questionnaire completed?

Completion approach	Frequency	Percent
Entirely with the beneficiary	308	34.5
Partially with the beneficiary, partially using existing staff knowledge	376	42.1
No response available from the beneficiary	209	23.4
Total	**893**	**100**

Table A1.6: Second follow-up outcomes questionnaire: How was this questionnaire completed?

Completion approach	Frequency	Percent
Entirely with the beneficiary	213	44.4
Partially with the beneficiary, partially using existing staff knowledge	168	35.0
No response available from the beneficiary	99	20.6
Total	**480**	**100**

There are few significant differences in the characteristics of those who have and have not been involved in completing the baseline outcomes questionnaire, which could introduce bias into the results. Women are significantly more likely to have been involved in completing all of the questionnaire, whereas men are more likely to not be involved at all – see Table A1.7.

Table A1.7: How was this questionnaire (baseline outcomes) completed? (By gender)

Completion approach	Males (percent)	Females (percent)
Entirely with the beneficiary	33	42*
Partially with the beneficiary, partially using existing staff knowledge	41	40
No response available from the beneficiary	26*	18
Number	**707**	**414**

* Indicates a significant difference between males and females

We have compared results between baseline and the first follow-up and second follow-up where sufficient data is available. Longitudinal analysis involves comparing data for the same group of people at each timepoint; therefore, those without data at both timepoints are excluded from the analysis. Some participants will not be eligible to complete a follow-up questionnaire if they joined the programme only recently.

We test for significant differences between baseline and follow-up using paired-sample t-tests when comparing mean values and using McNemar's test when comparing categorical variables. We report results that are significant at the five per cent level.
The evaluation team are working closely with MHCLG to improve the quality and coverage of the quantitative data available. Quantitative data will continue to be collected as more participants join and progress through the programme.

Regression analysis method

Regression analysis was used to explore the associates of change in ten key outcomes set out in Table A1.8 below. Due to the relatively small sample sizes in later time periods, the models reported here consider change from baseline to first follow-up (see above for the time periods this covers). For each outcome eight different multivariate regression models were estimated to explore whether any input variables are associated with changes in the outcome. The main associates considered are individual demographic characteristics, experience of the five target types of disadvantages, contact with the five

related key services, use of a range of support activities and average caseload of the local Changing Futures team providing support.

Regression analysis in this context provides a useful tool to identify the individual characteristics and use of support services that are associated with outcomes. The regression models should not be used as evidence of a causal relationship or of the direction of influence. For example, getting help to connect with family may help reduce contact with the criminal justice system but reduced contact with the criminal justice system may also mean families are more willing to reconnect with people. Further, there are likely to be unobserved factors that influence both the explanatory variables and the outcome.

Outcomes used in regression modelling

n denotes the number of respondents with valid observations at both baseline and first follow-up. Sample sizes in regression models are smaller due to missing observations on input variables. * This question is only asked to respondents who are not currently in stable accommodation. # Binary scales are derived from 3-point scales (-1, 0, 1).

Table A1.8: Key outcomes used in regression modelling

	Outcome	Change measured on scale:	n
1	ReQol score	integer	413
2	ability to cope without using drugs or alcohol	integer	311
3	ability to cope with mental health problems	integer	319
4	confidence that will be in stable accommodation in six months	integer	138*
5	feeling safe where currently living	integer	283
6	recent experience of rough sleeping	binary#	575
7	recent experience of homelessness	binary	562
8	recent experience of domestic abuse	binary	450
9	recent experience of the criminal justice system	binary	587
10	NDTA score	integer	471

In the regression analysis reported in Tables A2.8, A2.26, A2.29, A2.36, A2.37, A2.42, A2.43, A2.45, A2.52, A2.57 and A2.58 all integer outcomes are modelled using a linear model that treats the scale as if it were continuous; all integer outcomes are approximately normally distributed. For all binary outcomes 1 represents improvement (i.e. less recent experience of the issue in question) and 0 represents either no change or a worsening;

these are estimated as probit models.[***] In all cases only the sign and significance of the coefficient estimates are meaningful, showing the direction of the association. The magnitude should not be interpreted as a marginal effect.

For outcomes 1 to 9, a positive association indicates a relationship between receiving a particular type of support and an improvement in the outcome. However, for outcome 10 (the NDTA score) a reduction in score represents an improvement (a lower level of need and risk), so negative associations indicate an association between receiving support and an improvement in the outcome.

For each outcome, eight different multivariate regression models were estimated to explore whether any input variables are associated with changes in the outcome. The main associates considered are individual demographic characteristics, the five target forms of disadvantage, contact with five key associated services, a range of different types of support received and average caseload on the local Changing Futures team providing support.

Table A1.9: Regression models

Model	Description	Variables
(1)	Basic demographic variables (included in all models)	Dummy variables for each age band (30 to 49 and 50 plus). Youngest age group (under 30) is omitted category); female dummy; non-white dummy.
(2)	The five target types of disadvantage	Dummy variables for experience of: Mental health problems, drug/alcohol misuse, homelessness, domestic abuse, criminal justice system.
(3)	Number of types of disadvantage experienced	Dummy variable for each number of disadvantages experienced 2 to 5. 1 is the omitted category.
(4)	Contact with five key services	Dummy variables for recent contact (in the past three months as reported in first follow-up) with each service of: mental health services, substance misuse services, homelessness services, domestic abuse services, probation services.
(5)	Number of key services used.	Dummy variable for each number of services used 2 to 5. 1 is the omitted category.

[***] In all cases for outcomes 6. to 9. the raw change can take 3 values (-1, 0, 1). The dominant value is no change; in each case around 95 per cent of responses indicate no change. These outcomes are simplified to binary scales for the modelling.

(6)	Average caseload	Average caseload of local Changing Futures support team.
(7)	Number of types of support received	Number of different support activities used recently (in the past three months as reported in first follow-up (1 to 23).
(8)	Types of support received.	Dummy variable for use of each of the 23 named types of support received.

To present these results in an easily digestible form Models (1) to (7) are reported as separate columns with one table for each outcome (Tables A2.8, A2.26, A2.29, A2.36, A2.37, A2.42, A2.43, A2.45, A2.52, and A2.57). Model (8) estimates for all outcomes are presented in Table A2.58.

Partners survey

The survey includes questions relating to understanding, attitudes, culture and practice relevant to the programme's outcomes.

192 respondents to the baseline survey who gave their consent were sent invitations to complete the follow-up survey directly – 69 went on to complete the survey. In addition, Changing Futures area leads were encouraged to circulate a link to the survey as widely as possible amongst staff and volunteers working in the local system supporting people experiencing multiple disadvantage.

However, unlike the baseline survey, responses were more evenly distributed across the 15 funded areas; only two areas received fewer than 10 responses. Tables A1.10 to A1.12 provide a full breakdown of responses by area, sector and respondent role.

A third and final follow-up survey is planned for end of the programme.

Table A1.10: Partners survey responses by Changing Futures area

Area	Number of responses	Per cent
Bristol	2	0.4
Essex	61	12.4
Greater Manchester	55	11.2
Hull	28	5.7
Lancashire	55	11.2
Leicester	20	4.1
Northumbria	9	1.8
Nottingham	30	6.1
Plymouth	38	7.7
Sheffield	30	6.1
South Tees	28	5.7
Stoke-on-Trent	25	5.1
Surrey	42	8.6
Sussex	52	10.6
Westminster	16	3.3
TOTAL	**491**	**100**

Table A1.11: Partners survey responses: 'Which of the following best describes the sector that you mainly work or volunteer in?'

Sector	Number of responses	Percent
Multiple disadvantage	119	24.2
Housing and homelessness	110	22.4
Drug and alcohol services	44	9
Criminal justice and/or community safety	39	7.9
Mental health and wellbeing	37	7.5
Cross-sector	37	7.5
Social care	36	7.3
Public health	18	3.7
Domestic abuse and/or sexual violence	18	3.7
Physical health and wellbeing	17	3.5
Education, skills and training	5	1
Benefits/welfare rights	4	0.8
Other (Please specify)	7	1.4
Total	**491**	**100**

Table A1.12: Partners survey responses: 'Which of the following best describes your main role?'

Role	Number of responses	Per cent
Senior management	141	28.7
Strategy/commissioning	52	10.6
Service management	94	19.1
Frontline service delivery (working directly with individuals)	161	32.8
Lived experience involvement/co-production lead	31	6.3
Other (Please specify)	12	2.4
Total	**491**	**100**

Qualitative research

This round of qualitative fieldwork explored the topics set out in Table A1.13.

Table A1.13: Focus themes for second round of qualitative research, with associated outcomes as set out in the programme theory of change

Theme	Related service- and systems-level outcomes
Joining up support around the user: navigation, communication, and referral	Reduced service drop out/missed appointments/re-referrals for people experiencing multiple disadvantage Clear lines of communication/referral processes to other services Early identification of people at risk Clear referral pathways Specialist staff or key workers enable coordinated integrated access to specialist services
Trauma-informed approaches: the workforce and ways of working	Staff (including peer supporters and volunteers) feel valued and trusted across the service and system and have access to the training and support they need Staff have flexibility, autonomy and capacity to best meet the needs of people experiencing multiple disadvantage Reduced staff burnout

The qualitative research in this report is based primarily on interviews with five of the 15 areas, as well as some insight from our previous round of qualitative research with five other areas. The five Changing Futures areas were purposively sampled in discussion with the Department of Levelling Up, Housing and Communities (now called MHCLG) to provide representation from a range of geographical and administrative areas, and to include areas where it was felt that there would be most learning and insights to be gathered on the topics for discussion. Other funded areas will be sampled in future rounds of qualitative research.

We undertook interviews with a total of 91 people, as set out in Table A1.14. We consulted with area leads to identify the specific roles and individuals to be interviewed. Staff and stakeholders were purposively sampled to ensure that a range of sectors were represented and that respondents could contribute to our research questions.

Participants were selected by funded areas on the basis of their ability to consent to and take part in interviews with minimal risk of harm to their recovery. Participants who had progressed enough to be able to comment on the impact of the programme on themselves were prioritised. Participant interviews were secured in all five sampled areas. However, interviews were only conducted with 20 participants in total and these may not be representative of the wider population of participants.

Table A1.14: Breakdown of interviewees by role and area

Interviewee role	Bristol	Northumbria	South Tees	Stoke-on-Trent	Surrey	Total
Area leads	2	3	1	3	3	**12**
Other programme staff	6	2	4	4	7	**23**
Caseworkers/other frontline staff	5	10		3	7	**25**
Other stakeholders		1	5	4	1	**11**
Participants	1	6	4	3	6	**20**
Total	**14**	**22**	**14**	**17**	**24**	**91**

A qualitative data analysis software package, ATLAS.ti, was used to facilitate the coding and analysis process. A matrix-based approach was adopted to ensure that the coding and themes were scrutinised, cross-checked, and challenged. We took a collegiate approach to analysis, led by a senior member of the team, with researchers who had undertaken fieldwork conducting analysis and meeting internally to discuss emerging themes.

Peer researchers

The qualitative research was supported by a team of peer researchers. Peers were recruited through an open invitation to funded areas. They completed accredited training (OCN London Level 2 in Peer Research) prior to conducting the research.

The peer researchers supported the evaluation team to design the participant interview topic guide; check that the language and ordering of the questions were suitable; co-facilitated interviews with programme participants; and identified emerging themes and areas for improvement. Interviews with programme participants were undertaken jointly with evaluation team staff. Input from peer researchers was moderated by the research team to ensure that their observations were supported by data. To make sure that the process ran smoothly, and all researchers involved in interviews felt prepared, measures put in place included:

- An introductory meeting between the evaluation team and peer researchers to run through the plan for this stage of fieldwork, answer questions, and get to know one another.

- A briefing meeting with the peer researcher and evaluation team researcher who would be conducting the participant interview to provide any useful background information,

decide how the questions would be split up and answer any questions that the peer researcher may have had.

After interviews were completed, Revolving Doors contacted the interviewees to get their feedback and check if there were any issues arising. Revolving Doors also held a debrief session with all peer researchers who had conducted participant interviews to discuss the findings, reflect on the process, and consider whether any improvements could be made to this aspect of the evaluation.

Appendix 2: Participant data tables

Table A2.1: Current engagement status of participants

Engagement status	Frequency	Percent
Actively engaged on the programme	1,033	58.8
Disengaged from the programme	358	20.4
Moved on from the programme	338	19.2
Not known	27	1.5
Total	**1,756**	**100**

Table A2.2: Primary reason for moving on

Reason for moving on	Frequency	Percent
Left the area	41	12.5
Support no longer required	136	41.3
Receiving appropriate support outside of the programme	126	38.3
Other	23	7.0
Not applicable	3	0.9
Total	**329**	**100**

Table A2.3: Primary reason for disengagement

Primary reason for disengagement	Frequency	Percent
Cannot be reached/No response to engagement efforts e.g. phone lost, accommodation situation changed	195	55.9
Cannot be reached due to interaction with the criminal justice system e.g. long custodial sentence	56	16.0
Cannot be engaged due to poor health or hospitalisation / interaction with the mental health system	8	2.3
Deceased	25	7.2
Consent to be part of the programme withdrawn	28	8.0
Other	34	9.7
Not applicable	3	0.9
Total	**349**	**100**

Table A2.4: ReQoL score at baseline and first follow-up (n=413)

ReQoL	Baseline (mean score)	First follow-up (mean score)	Significance (two-tailed)
Total ReQoL score	13.15	16.56	$p < 0.01$

Table A2.5: ReQoL score at baseline and second follow-up (n=232)

ReQoL	Baseline (mean score)	Second follow-up (mean score)	Significance (two-tailed)
Total ReQoL score	13.03	16.77	$p < 0.01$

Table A2.6: Percentage of participants reporting a meaningful change in ReQoL between baseline and first follow-up

Change in ReQoL	Frequency	Percent
Score worsened	40	9.7
No reliable change	223	54.0
Score improved	150	36.3
Total	**413**	**100**

Table A2.7: Percentage of participants reporting a meaningful change in ReQoL between baseline and second follow-up

Change in ReQoL	Frequency	Percent
Score worsened	26	11.2
No reliable change	113	48.7
Score improved	93	40.1
Total	**232**	**100**

Table A2.8: Associates of change in total ReQoL score between baseline and first follow-up. Standard errors in parentheses. ***p<0.01, **p<0.05

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	1.300	0.366	0.337	0.566	0.572	1.207	1.117
	(1.028)	(1.410)	(1.405)	(1.263)	(1.246)	(1.268)	(1.016)
age_50 plus	1.523	0.735	0.983	0.761	0.803	1.713	1.151
	(1.240)	(1.743)	(1.718)	(1.507)	(1.479)	(1.585)	(1.233)
female	2.175***	2.516*	2.204*	1.648	1.789*	1.858*	1.801**
	(0.807)	(1.305)	(1.137)	(1.049)	(0.919)	(0.971)	(0.805)
non-white	-2.980**	-2.821	-2.756	-3.920**	-3.959**	-3.316**	-3.241**
	(1.312)	(1.910)	(1.864)	(1.616)	(1.589)	(1.426)	(1.298)
mental health		-0.972					
		(4.010)					
drugs or alcohol		-0.254					
		(2.152)					
homelessness		-1.053					
		(1.485)					
domestic abuse		-0.459					
		(1.315)					
criminal justice system		2.405					
		(1.496)					
2 disadvantages			-1.389				
			(5.014)				
3 disadvantages			0.848				
			(4.834)				
4 disadvantages			0.994				
			(4.644)				
5 disadvantages			0.301				
			(4.619)				

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				-1.091			
				(1.228)			
contact with domestic abuse services				0.477			
				(1.502)			
contact with mental health services				-0.276			
				(0.897)			
contact with homeless services				0.627			
				(0.929)			
contact with probation services				-0.482			
				(0.973)			
contact with 2 key services					0.706		
					(1.195)		
use 3 key services					0.132		
					(1.291)		
contact with 4 key services					1.047		
					(1.673)		
contact with 5 key services					-6.041**		
					(2.836)		
average caseload						-0.024	
						(0.097)	
No. of support activities							0.421***
							(0.125)

Constant	1.993**	3.308	2.527	2.831**	2.343	2.212*	0.355
	(0.951)	(4.702)	(4.796)	(1.326)	(1.436)	(1.311)	(1.057)
Observations	376	220	220	297	297	376	375
R-squared	0.036	0.043	0.035	0.038	0.054	0.036	0.065

See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.9: NDTA score at baseline and first follow-up (n=357)

NDTA	Baseline (mean score)	First follow-up (mean score)	Significance (two-tailed)
Total NDTA score	22.20	18.90	p <0.01

Table A2.10: NDTA score at baseline and second follow-up (n=138)

NDTA	Baseline (mean score)	Second follow-up (mean score)	Significance (two-tailed)
Total NDTA score	22.91	19:93	p <0.01

A2.11: Percentage of participants receiving a change in total NDTA score between baseline and first follow-up

Change in total NDTA score	Frequency	Percent
Score improved	96	26.9
No meaningful change	240	67.2
Score worsened	21	5.9
Total	**357**	**100**

Table A2.12: Percentage of participants receiving a change in total NDTA score between baseline and second follow-up

Change in total NDTA score	Frequency	Percent
Score improved	43	31.2
No meaningful change	78	56.5
Score worsened	17	12.3
Total	**138**	**100**

Table A2.13: Change in ReQoL score by change in NDTA score between baseline and first follow-up

	NDTA score worsened (**Percent**)	No reliable change **(Percent)**	**NDTA** score improved **(Percent)**
ReQoL score worsened	50	13	4.4
No meaningful change	50	58	42.6
ReQoL score improved	0	29	52.9
Base	6	162	68

Table A2.14: Participants reporting a change in levels of anxiety between baseline and follow-up

Change in anxiety levels	**Frequency**	**Percent**
Score improved	132	53.2
No change	60	24.2
Score worsened	56	22.6
Total	**248**	**100**

Table A2.15: How much do you agree or disagree with this statement: 'I am able to effectively manage my mental health difficulties.'?

Extent of agreement	Baseline		First follow-up	
	Frequency	Percent	Frequency	Percent
Strongly agree (score 1)	8	2.3	8	2.3
Agree (score 2)	24	6.8	48	13.7
Neither agree nor disagree (score 3)	60	17.1	88	25.1
Disagree (score 4)	119	33.9	114	32.5
Strongly disagree (score 5)	120	34.2	76	21.7
Don't know / Don't want to say	20	5.7	17	4.8
Total	351	100.0	351	100

Ability to manage mental health	Baseline	First follow-up	Significance
Mean score	3.95	3.63	p<0.01

Table A2.16: Change in responses to the question: How much do you agree or disagree with this statement: 'I am able to effectively manage my mental health difficulties' between baseline and first follow-up

Change in responses	Frequency	Percent
Improved	114	35.7
Maintained positive	16	5.0
Maintained neutral	32	10.0
Maintained negative	107	33.5
Worse	50	15.7
Total	**319**	**100**

Table A2.17: Please describe your physical health over the last week (n=248)

Physical health	Baseline (percent)	Second follow-up (percent)
No problems (score 1)	27.4	30.6
Slight problems (score 2)	15.3	19.8
Moderate problems (score 3)	27.4	24.2
Severe problems (score 4)	20.6	18.5
Very severe problems (score 5)	9.3	6.9
Number	**248**	**248**

Physical health	Baseline	Second follow-up	Significance
Mean score	2.69	2.51	p=0.005

Table A2.18: Change in responses to question 'Please describe your physical health over the last week' between baseline and second follow-up

Change in responses	Frequency	Percent
Score improved	72	29.0
Maintained positive	69	27.8
Maintained negative	68	27.4
Score worsened	39	15.7
Total	**248**	**100**

Table A2.19: How many times in the last three months have you been to the Accident and Emergency (A&E) Department, if at all? Comparison of baseline and first follow-up (n=360)

Times been to A&E in last three months	Baseline	First follow-up	Significance
Mean	1.07	0.64	p=0.006
Minimum	0	0	
Maximum	45	8	

Table A2.20: How many times in the last three months have you been to the Accident and Emergency (A&E) Department, if at all? Comparison of baseline and second follow-up (n=197)

Times been to A&E in last three months	Baseline	Second follow-up	Significance
Mean	1.14	0.74	p=0.134
Minimum	0	0	
Maximum	45	20	

Table A2.21: How many times in the last three months has an ambulance been called to assist you, if at all? Comparison of baseline and first follow-up (n=359)

Times an ambulance called for assistance in last three months	Baseline	First follow-up	Significance
Mean	0.97	0.6	p=0.034

Table A2.22: How many times in the last three months has an ambulance been called to assist you, if at all? Comparison of baseline and second follow-up (n=195)

Times an ambulance called for assistance in last three months	Baseline	Second follow-up	Significance (two-tailed)
Mean	1.17	0.77	p=0.277

Table A2.23: Thinking about the past three months, how much would you agree or disagree with this statement: I have coped with problems without misusing drugs or alcohol? (n=311)

Extent of agreement	Baseline (percent)	First follow-up (percent)
Strongly agree	4.5	5.8
Agree	6.4	12.2
Neither agree nor disagree	15.4	19.3
Disagree	35.0	34.1
Strongly disagree	38.6	28.6
Number	**311**	**311**

I have coped with problems without misusing drugs or alcohol	Baseline	First follow-up	Significance
Mean score	3.97	3.68	p<0.01

Table A2.24: Change in response to the question 'How much would you agree or disagree with this statement: I have coped with problems without misusing drugs or alcohol?' between baseline and first follow-up (n=311)

Change in response	Frequency	Percent
Improved ability to cope	98	31.5
No change – positive answer	15	4.8
No change – neutral answer	23	7.4
No change – negative answer	123	39.5
Worse ability to cope	52	16.7
Total	**311**	**100**

Table A2.25: Thinking about the past three months, how much would you agree or disagree with this statement: I have coped with problems without misusing drugs or alcohol?

Extent of agreement	Baseline (percent)	Second follow-up (percent)
Strongly agree	2.9	2.4
Agree	5.3	14.1
Neither agree nor disagree	14.1	14.7
Disagree	34.7	32.9
Strongly disagree	42.9	35.9
Number	**170**	**170**

I have coped with problems without misusing drugs or alcohol	Baseline	Second follow-up	Significance
Mean score	4.09	3.86	p=0.011

Table A2.26: Associates of change in ability to cope without using drugs or alcohol between baseline and first follow-up.

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_3049	0.182	0.032	0.005	0.160	0.218	0.090	0.153
	(0.204)	(0.256)	(0.255)	(0.213)	(0.211)	(0.263)	(0.207)
age_50plus	0.447*	0.263	0.215	0.408	0.418	0.228	0.401
	(0.248)	(0.324)	(0.321)	(0.260)	(0.255)	(0.335)	(0.252)
female	0.160	-0.114	0.005	0.119	0.192	0.037	0.129
	(0.153)	(0.230)	(0.202)	(0.178)	(0.157)	(0.189)	(0.156)
non-white	0.744**	0.549	0.546	0.659**	0.635**	0.545	0.729**
	(0.297)	(0.449)	(0.450)	(0.316)	(0.311)	(0.327)	(0.298)
mental health		-0.556					
		(0.624)					
drugs or alcohol		-					
homelessness		-0.164					
		(0.263)					
domestic abuse		0.216					
		(0.247)					
criminal justice system		-0.291					
		(0.274)					
2 disadvantages			0.664				
			(0.485)				
3 disadvantages			-				
4 disadvantages			0.093				
			(0.343)				
5 disadvantages			0.129				
			(0.344)				

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.110			
				(0.209)			
contact with domestic abuse services				0.117			
				(0.252)			
contact with mental health services				-0.056			
				(0.155)			
contact with homelessness services				-0.111			
				(0.156)			
contact with probation services				-0.076			
				(0.169)			
contact with 2 key services					-0.120		
					(0.202)		
contact with 3 key services					-0.228		
					(0.218)		
contact with 4 key services					-0.433		
					(0.275)		
contact with 5 key services					-0.227		
					(0.497)		
average caseload						-0.028	
						(0.018)	
No of support services							0.032
							(0.024)
Constant	-0.007	1.011	0.068	0.085	0.128	0.250	-0.119
	(0.192)	(0.714)	(0.364)	(0.228)	(0.244)	(0.255)	(0.212)

Observations	284	168	168	278	278	284	283
R-squared	0.036	0.030	0.027	0.037	0.042	0.044	0.042

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.27: Contact with criminal justice system at baseline and first follow-up (base=438).

Contact with criminal justice system	Baseline (percent)	First follow-up (percent)	Significance
Received a caution	6.4	4.1	p=0.087
Received an injunction or criminal behaviour order	5.3	3.4	p=0.185
Been arrested	18.9	17.4	p=0.489
Been convicted of a crime	8.7	8.0	p=0.766
Spent time in prison	9.1	11.2	p=0.163
None of these	61.4	64.6	p=0.098

Table A2.28: Contact with criminal justice system at baseline and second follow-up (base=204). * Indicates a significant difference between baseline and second follow-up

Contact with criminal justice system	Baseline (percent)	Second follow-up (percent)	Significance
Received a caution	6.9	7.4	p=1.00
Received an injunction or criminal behaviour order	5.4	3.5	p=0.388
Been arrested	17.3	15.8	p=0.761
Been convicted of a crime	8.9	6.9	p=0.481
Spent time in prison	9.4	13.4	p=0.115
None of these*	64.4	56.9	p=0.028

Table A2.29: Associates of change in recent experience of the criminal justice system between baseline and first follow-up.

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	-0.191	-0.613***	-0.636***	-0.320	-0.344	-0.202	-0.174
	(0.173)	(0.235)	(0.226)	(0.209)	(0.213)	(0.183)	(0.176)
age_50 plus	-0.512**	-1.193***	-1.100***	-0.727**	-0.773**	-0.460	-0.510**
	(0.243)	(0.395)	(0.383)	(0.311)	(0.311)	(0.256)	(0.247)
female	-0.012	0.111	0.051	0.153	0.082	-0.042	-0.073
	(0.150)	(0.244)	(0.211)	(0.194)	(0.175)	(0.156)	(0.153)
non-white	0.257	0.194	0.178	0.265	0.249	0.247	0.275
	(0.206)	(0.307)	(0.294)	(0.259)	(0.257)	(0.211)	(0.207)
mental health		-0.737					
		(0.832)					
drugs or alcohol		0.609					
		(0.605)					
homelessness		-0.039					
		(0.357)					
domestic abuse		0.281					
		(0.277)					
criminal justice system		-					
2 disadvantages			-				
3 disadvantages			3.809				
			(178.387)				
4 disadvantages			4.177				
			(178.387)				
5 disadvantages			4.502				
			(178.387)				

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.015			
				(0.228)			
contact with domestic abuse services				-0.214			
				(0.295)			
contact with mental health services				0.198			
				(0.170)			
contact with homelessness services				0.152			
				(0.169)			
contact with probation services				-0.015			
				(0.181)			
contact with 2 key services					-0.147		
					(0.242)		
contact with 3 key services					0.129		
					(0.248)		
contact with 4 key services					0.100		
					(0.295)		
contact with 5 key services					-0.132		
					(0.592)		
average caseload						0.035*	
						(0.020)	
no. of support services							0.041
							(0.022)

Constant	-0.958***	-0.554	-4.905	-0.992***	-0.810***	-1.314***	-1.145***
	(0.162)	(1.060)	(178.387)	(0.230)	(0.270)	(0.262)	(0.187)
Observations	500	224	254	372	372	500	498

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.30: In the last 3 months have you been a victim of violent crime, such as being physically assaulted, verbally abused or threatened? (n=439)

Victim of other crime	Baseline (percent)	First follow-up (percent)	Significance
Yes	43.7	34.4	p<0.01

Table A2.31: In the last 3 months have you been a victim of other crime, such as your belongings being stolen or damaged? (n=440)

Victim of other crime	Baseline (percent)	First follow-up (percent)	Significance
Yes	38.0	27.7	p<0.01

Table A2.32: Experience of domestic abuse in the last 3 months (n=450)

Experience of domestic abuse	Baseline (percent)	First follow-up (percent)	Significance
Yes	24.0	19.3	p=0.009

Table A2.33: Experience of domestic abuse in the last 3 months (n=248)

Experience of domestic abuse	Baseline (percent)	Second follow-up (percent)	Significance
Yes	23.4	19.8	p=0.150

Table A2.34: How much do you agree or disagree with this statement: I feel safe where I am living

Extent of agreement	Baseline (percent)		First follow-up (percent)
Strongly agree		8.1	10.6
Agree		33.6	39.6
Neither agree nor disagree		18.4	23
Disagree		22.6	17.0
Strongly disagree		17.3	9.9
Number		**283**	**283**
I feel safe where I am living	Baseline	First follow-up	Significance
Mean score	3.07	2.76	p<0.01

Table A2.35: Change in response to question 'How much do you agree or disagree with this statement: I feel safe where I am living' between baseline and first follow-up

Change in response	Frequency	Percent
Score improved	84	29.7
Maintained positive answer	79	27.9
Maintained neutral answer	28	9.9
Maintained negative answer	48	17.0
Score worsened	44	15.5
Total	**283**	**100**

Table A2.36: Associates of change in recent experience of domestic abuse between baseline and first follow-up.

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	-0.628***	-0.755***	-0.720***	-0.799***	-0.838***	-0.710***	-0.618***
	(0.211)	(0.280)	(0.257)	(0.265)	(0.260)	(0.232)	(0.218)
age_50 plus	-0.776***	-0.594	-0.635	-0.920**	-1.017***	-0.822**	-0.769***
	(0.293)	(0.412)	(0.354)	(0.383)	(0.385)	(0.324)	(0.298)
female	0.565***	-0.021	0.451**	0.435	0.410	0.492**	0.484**
	(0.187)	(0.267)	(0.229)	(0.257)	(0.228)	(0.207)	(0.193)
non-white	-0.095	0.022	0.056	-0.294	-0.318	-0.204	-0.091
	(0.329)	(0.440)	(0.385)	(0.544)	(0.531)	(0.342)	(0.332)
mental health		-					
drugs or alcohol		-0.061					
		(0.552)					
homelessness		-0.045					
		(0.365)					
domestic abuse		-					
criminal justice system		0.213					
		(0.379)					
2 disadvantages			-				
3 disadvantages			3.780				
			(188.163)				
4 disadvantages			4.302				
			(188.162)				
5 disadvantages			4.876				
			(188.162)				

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.297			
				(0.304)			
contact with domestic abuse services				0.131			
				(0.345)			
contact with mental health services				0.267			
				(0.230)			
contact with homeless services				-0.034			
				(0.237)			
contact with probation services				0.449*			
				(0.243)			
contact with 2 key services					0.436		
					(0.350)		
contact with 3 key services					0.286		
					(0.381)		
contact with 4 key services					0.485		
					(0.420)		
contact with 5 key services					1.627**		
					(0.725)		
average caseload						0.080***	
						(0.024)	
No of support services							0.078***
							(0.027)
Constant	-1.068***	-0.253	-5.321	-1.226***	-1.203***	-1.869***	-1.472***
	(0.199)	(0.719)	(188.162)	(0.303)	(0.373)	(0.324)	(0.248)
Observations	392	136	228	298	298	392	390

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.37: Associates of change in feeling safe where currently living between baseline and first follow-up.

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	0.516**	0.712***	0.665**	0.455*	0.495*	0.654**	0.496**
	(0.217)	(0.259)	(0.260)	(0.273)	(0.269)	(0.299)	(0.218)
age_50 plus	0.515**	0.682**	0.650**	0.523	0.565*	0.659	0.495
	(0.250)	(0.303)	(0.299)	(0.305)	(0.302)	(0.355)	(0.252)
female	0.217	0.227	0.150	0.215	0.259	0.031	0.199
	(0.177)	(0.259)	(0.228)	(0.223)	(0.210)	(0.235)	(0.178)
non-white	0.076	-0.091	-0.006	0.028	0.035	0.014	0.056
	(0.272)	(0.356)	(0.341)	(0.344)	(0.340)	(0.314)	(0.273)
mental health		-0.424					
		(0.607)					
drugs or alcohol		-0.103					
		(0.394)					
homelessness		0.397					
		(0.267)					
domestic abuse		0.021					
		(0.237)					
criminal justice system		0.232					
		(0.272)					
2 disadvantages			0.458				
			(0.680)				
3 disadvantages			0.401				
			(0.661)				
4 disadvantages			0.610				
			(0.627)				
5 disadvantages			0.802				
			(0.628)				

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.078			
				(0.285)			
contact with domestic abuse services				0.344			
				(0.404)			
contact with mental health services				-0.212			
				(0.187)			
contact with homeless services				0.097			
				(0.196)			
contact with probation services				-0.166			
				(0.204)			
contact with 2 key services					-0.135		
					(0.229)		
contact with 3 key services					-0.328		
					(0.263)		
contact with 4 key services					-0.195		
					(0.339)		
contact with 5 key services					0.729		
					(0.755)		
average caseload						-0.033	
						(0.020)	
No of support services							0.031
							(0.028)
Constant	-0.162	-0.300	-0.861	-0.081	-0.064	0.124	-0.281
	(0.199)	(0.735)	(0.645)	(0.272)	(0.292)	(0.262)	(0.227)

Observations	255	150	150	196	196	255	254
R-squared	0.029	0.092	0.076	0.047	0.048	0.040	0.034

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.38: Experience of homelessness in the past 3 months – comparison of baseline and first follow-up (n=562)

Experience of homelessness	Baseline (percent)	First follow-up (percent)	Significance
Yes	64.1	57.3	p<0.01

Table A2.39: Experience of homelessness in the past 3 months – comparison of baseline and second follow-up (n=292)

Experience of homelessness	Baseline (percent)	Second follow-up (percent)	Significance
Yes	58.6	55.8	p=0.374

Table A2.40: Experience of rough sleeping in the past 3 months – comparison of baseline and first follow-up (n=575)

Experience of rough sleeping	Baseline (percent)	First follow-up (percent)	Significance
Yes	32.5	23.5	p<0.01

Table A2.41: Experience of rough sleeping in the past 3 months – comparison of baseline and second follow-up (n=299)

Experience of rough sleeping	Baseline (percent)	Second follow-up (percent)	Significance
Yes	30.8	21.1	p=0.001

Table A2.42: Associates of change in recent rough sleeping between baseline and first follow-up.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	0.036	-0.205	-0.181	0.004	0.001	-0.013	0.023
	(0.178)	(0.252)	(0.245)	(0.214)	(0.213)	(0.197)	(0.179)
age_50 plus	-0.722***	-1.319***	-1.193**	-0.708**	-0.722**	-0.724**	-0.741***
	(0.264)	(0.491)	(0.470)	(0.311)	(0.312)	(0.287)	(0.266)
female	-0.168	0.067	-0.242	-0.056	-0.080	-0.283	-0.190
	(0.149)	(0.257)	(0.223)	(0.186)	(0.169)	(0.162)	(0.152)
non-white	-0.049	-0.195	-0.127	-0.342	-0.329	-0.183	-0.051
	(0.235)	(0.349)	(0.347)	(0.331)	(0.329)	(0.242)	(0.236)
mental health		-					
drugs or alcohol		0.098					
		(0.595)					
homelessness		-					
domestic abuse		-0.212					
		(0.273)					
criminal justice system		0.980*					
		(0.521)					
2 disadvantages			3.627				
			(230.033)				
3 disadvantages			-				
4 disadvantages			4.039				
			(230.033)				
5 disadvantages			4.323				
			(230.033)				

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				-0.094			
				(0.223)			
contact with domestic abuse services				0.030			
				(0.270)			
contact with mental health services				-0.032			
				(0.162)			
contact with homeless services				0.098			
				(0.162)			
contact with probation services				0.096			
				(0.176)			
contact with 2 key services					0.044		
					(0.223)		
contact with 3 key services					-0.064		
					(0.240)		
contact with 4 key services					0.248		
					(0.280)		
contact with 5 key services					-		
average caseload						0.026	
						(0.019)	
No. of support services							0.020
							(0.022)
Constant	-0.910***	-1.579**	-4.859	-0.917***	-0.879***	-1.154***	-0.983***
	(0.169)	(0.628)	(230.033)	(0.233)	(0.262)	(0.246)	(0.190)

Observations	498	217	241	380	372	498	496

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.43: Associates of change in recent homelessness between baseline and first follow-up.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	-0.148	-0.362	-0.291	-0.101	-0.122	-0.023	-0.159
	(0.199)	(0.299)	(0.283)	(0.241)	(0.229)	(0.229)	(0.200)
age_50 plus	-0.089	-0.117	-0.180	-0.102	-0.170	0.149	-0.118
	(0.240)	(0.377)	(0.354)	(0.294)	(0.285)	(0.272)	(0.243)
female	0.009	0.285	0.118	0.051	0.018	-0.060	-0.049
	(0.161)	(0.291)	(0.242)	(0.206)	(0.182)	(0.176)	(0.167)
non-white	0.098	0.297	0.186	0.034	0.011	0.019	0.066
	(0.246)	(0.380)	(0.357)	(0.310)	(0.293)	(0.253)	(0.249)
mental health		-					
drugs or alcohol		-					
homelessness		-					
domestic abuse		-0.389					
		(0.299)					
criminal justice system		-0.631					
		(0.337)					
2 disadvantages			-				
3 disadvantages			3.438				
			(225.159)				
4 disadvantages			4.157				
			(225.159)				
5 disadvantages			3.840				
			(225.159)				

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				-0.149			
				(0.261)			
contact with domestic abuse services				-0.275			
				(0.313)			
contact with mental health services				0.355**			
				(0.178)			
contact with homeless services				-0.612***			
				(0.202)			
contact with probation services				-0.275			
				(0.215)			
contact with 2 key services					0.062		
					(0.228)		
contact with 3 key services					-0.053		
					(0.245)		
contact with 4 key services					-0.534		
					(0.379)		
contact with 5 key services					-		
average caseload						0.022	
						(0.020)	
No. of support services							0.040
							(0.024)
Constant	-1.159***	-0.306	-5.114	-0.981***	-1.042***	-1.370***	-1.316***

	(0.186)	(0.435)	(225.159)	(0.254)	(0.274)	(0.268)	(0.212)
Observations	485	198	246	376	370	485	483

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.44: On a scale of very confident to not at all confident, how confident do you feel that you will be in stable accommodation in 6-months' time? Comparison of baseline and first follow-up

Level of confidence	Baseline (percent)	First follow-up (percent)
Very confident	2	8
Fairly confident	27	30
Not very confident	44	42
Not at all confident	27	20
Number	**138**	**138**

Level of confidence	Baseline	First follow-up	Significance
Mean score	2.96	2.75	p=0.017

Table A2.45: Associates of change in confidence that will be in stable accommodation in 6-months' time between baseline and first follow-up.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	0.061	0.395	0.493	0.094	-0.064	-0.239	0.082
	(0.296)	(0.389)	(0.426)	(0.388)	(0.363)	(0.333)	(0.294)
age_50 plus	-0.287	0.062	0.117	-0.147	-0.355	-0.527	-0.232
	(0.396)	(0.494)	(0.524)	(0.470)	(0.459)	(0.485)	(0.395)
female	-0.072	-0.460	-0.452	-0.229	-0.193	-0.257	-0.031
	(0.255)	(0.374)	(0.345)	(0.323)	(0.287)	(0.272)	(0.255)
non-white	-0.070	-0.693	-0.254	-0.484	-0.471	0.097	-0.104
	(0.365)	(0.505)	(0.493)	(0.450)	(0.444)	(0.353)	(0.364)
mental health		-0.116					
		(0.917)					
drugs or alcohol		-2.115***					
		(0.792)					
homelessness		-					
domestic abuse		0.401					
		(0.356)					
criminal justice system		0.633					
		(0.478)					
2 disadvantages			0.652				
			(1.082)				
3 disadvantages			-				
4 disadvantages			-0.567				
			(0.635)				
5 disadvantages			-0.198				
			(0.601)				

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.005			
				(0.355)			
contact with domestic abuse services				-0.008			
				(0.475)			
contact with mental health services				0.054			
				(0.305)			
contact with homeless services				-0.494*			
				(0.275)			
contact with probation services				0.181			
				(0.278)			
contact with 2 key services					-0.273		
					(0.372)		
contact with 3 key services					-0.466		
					(0.390)		
contact with 4 key services					-0.441		
					(0.449)		
contact with 5 key services					0.198		
					(0.729)		
average caseload						0.000	
						(0.029)	
No. of support services							-0.061
							(0.037)
Constant	0.701**	1.950	0.800	0.989**	1.212***	0.699	0.949***
	(0.274)	(1.163)	(0.577)	(0.382)	(0.419)	(0.365)	(0.311)

Observations	127	76	76	103	103	127	127
R-squared	0.009	0.122	0.052	0.061	0.044	0.009	0.030

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.46: Please could you tell me what your main sources of income have been in the last 3 months? Comparison between baseline and first follow-up.

	Baseline percent	First follow-up percent
Universal credit*	76.5	80.2
Other benefits*	36.8	43.4
Paid work	1.7	1.8
Begging	6.7	4.9
Sex work	4.1	3.4
None of the above	3.1	3.4

* Indicates a significant difference between baseline and first follow-up (n=655)

Table A2.47: Please could you tell me what your main sources of income have been in the last 3 months? Comparison between baseline and second follow-up.

	Baseline percent	Second follow-up percent
Universal credit	75.9	77.9
Other benefits*	38.4	49.9
Paid work	1.7	1.4
Begging*	8.3	4.9
Sex work	4.6	5.7
None of the above	2.9	3.2

* Indicates a significant difference between baseline and first follow-up (n=349)

Table A2.48 If you are currently in debt or behind on your bills, how much do you agree or disagree that you are able to manage paying these off? Comparison between baseline and first follow-up

	Baseline (percent)	First follow-up (percent)
Strongly agree	6	8
Agree	17	24
Neither agree nor disagree	24	30
Disagree	22	20
Strongly disagree	31	18
Number	**211**	**211**

In debt or behind on bills	Baseline	First follow-up	Significance
Mean score	3.55	3.18	p<0.01

Table A2.49: If you needed someone to talk to, who would you turn to first (not including your support worker)? Comparison of baseline and first follow-up (n=395)

Who you would turn to first if needed	Baseline (percent)	First follow-up (percent)	Significance
No-one	17.2	10.4	p<0.01

Table A2.50: If you needed someone to talk to, who would you turn to first (not including your support worker)? Comparison of baseline and second follow-up (n=207)

Who you would turn to first if needed	Baseline (percent)	Second follow-up (percent)	Significance
No-one	17.4	10.6	p=0.038

Table A2.51: Thinking about any family members you have that you do not live with, do you feel well connected to them? Comparison of baseline and first follow-up (n=366)

Feel well connected to family members with whom you don't live	Baseline (percent)	First follow-up (percent)	Significance
Yes	56.3	61.2	p=0.047

Table A2.52: Associates of change in NDTA score between baseline and first follow-up.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	-0.376	-0.009	0.319	0.378	0.384	-0.065	-0.047
	(1.128)	(1.510)	(1.492)	(1.477)	(1.473)	(1.222)	(1.130)
age_50 plus	-0.435	-0.849	-0.584	-0.010	0.063	0.534	0.104
	(1.345)	(1.806)	(1.796)	(1.823)	(1.854)	(1.484)	(1.390)
female	1.052	1.638	1.623	1.927	1.603	1.068	1.378
	(0.883)	(1.412)	(1.201)	(1.261)	(1.152)	(0.958)	(0.923)
non-white	-2.433	-2.378	-2.089	-1.902	-2.446	-2.267	-2.718*
	(1.586)	(2.299)	(2.270)	(2.096)	(2.085)	(1.610)	(1.610)
mental health		1.268					
		(5.700)					
drugs or alcohol		-1.608					
		(2.350)					
homelessness		0.792					
		(1.710)					
domestic abuse		-0.527					
		(1.389)					
criminal justice system		-1.272					
		(1.692)					
2 disadvantages			6.163				
			(5.342)				
3 disadvantages			1.867				
			(4.876)				
4 disadvantages			0.211				
			(4.645)				
5 disadvantages			0.980				
			(4.615)				

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				2.085			
				(1.551)			
contact with domestic abuse services				0.301			
				(1.948)			
contact with mental health services				0.001			
				(1.100)			
contact with homeless services				-0.572			
				(1.090)			
contact with probation services				2.154			
				(1.153)			
contact with 2 key services					0.246		
					(1.534)		
contact with 3 key services					0.724		
					(1.599)		
contact with 4 key services					1.230		
					(1.938)		
contact with 5 key services					5.740		
					(3.919)		
average caseload						0.213**	
						(0.105)	
No. of support services							-0.248
							(0.143)
Constant	-4.046***	-4.488	-6.628	-5.128***	-4.768***	-6.294***	-2.630**
	(1.049)	(6.227)	(4.690)	(1.588)	(1.814)	(1.526)	(1.198)

Observations	393	195	195	239	239	393	325
R-squared	0.010	0.029	0.042	0.040	0.026	0.020	0.023

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.53: In the past 3 months, have you been in contact with any of the following services?

Services	Baseline (percent)	First follow-up (percent)	Significance
Substance misuse services (232)	53.0	55.2	p=0.609
Mental health services (536)	48.3	51.1	p=0.245
Probation service* (650)	34.8	29.5	p=0.015
Homelessness services (395)	49.4	49.1	p=1.00
Domestic abuse services (129)	34.9	41.1	p=0.215
Other services* (650)	12.2	19.4	p<0.01
None (650)	4.9	4.8	p=1.00

Base sizes in parentheses. Base for substance misuse, mental health, homelessness and domestic abuse services relates only to participants with reported recent experience of the associated form of disadvantage at baseline. * Indicates significant difference between baseline and first follow-up.

Table 62: In the past 3 months, have you been in contact with any of the following services? (n=347)

Services	Baseline (percent)	Second follow-up (percent)	Significance
Substance misuse services (125)	64	54.4	p=0.119
Mental health services (296)	50	48.6	p=0.749
Probation service (347)	34.3	29.4	p=0.139
Homelessness services (194)	44.8	42.3	P=0.630
Domestic abuse services (73)	39.7	47.9	p=0.286
Other services* (347)	12.4	26.5	p<0.01
None (347)	4.6	6.1	p=0.50

Base sizes in parentheses. Base for substance misuse, mental health, homelessness and domestic abuse services relates only to participants with reported recent experience of the associated form of disadvantage at baseline. *** Indicates significant difference between baseline and second follow-up**

Table A2.55: In the past 3 months, have you been in contact with any of the following services? Cumulative percentages baseline to third follow-up.

	Baseline	First follow-up	Second follow-up	Third follow-up
Domestic abuse (n=166)	19	25	28	33
Mental health services (n=185)	42	57	69	72
Homelessness services (n=187)	29	57	64	71
Probation service (n=175)	42	56	60	62
Substance misuse services (n=190)	56	72	80	82
Other services (n=173)	9	24	43	52

Base sizes in parentheses.

Table A2.56: In the past 3 months, have you received support with any of the following things? Cumulative percentages baseline to third follow-up.

	Baseline	First follow-up	Second follow-up	Third follow-up
Setting up a bank account (168)	8	16	20	24
Help or advice with money problems (178)	21	40	51	62
Budgeting (167)	14	24	30	40
Benefits applications (180)	23	38	44	54
Addressing housing problems (189)	54	75	82	84
Being supported to find or move into accommodation (188)	47	65	72	80
Helping make your accommodation safer (179)	28	42	49	56
Support from the police with violence or abuse from a partner or family members (162)	11	16	22	26
Cleaning/maintaining accommodation (172)	11	19	25	37
Attending appointments (183)	38	64	76	85
Accessing a GP (181)	24	47	60	72
Accessing a dentist (160)	8	12	13	18
Accessing adult social care (166)	13	22	26	32
Helping you to keep any probation requirements (166)	10	16	24	28
Obtaining ID (165)	4	11	14	19
Legal aid (160)	4	8	11	12
Understanding your rights and helping you take action (163)	14	27	31	37
Introducing you to local services (176)	23	38	49	56
Introducing you to people or groups in the community (166)	10	22	30	40
(Re)connecting with family members (162)	2	11	15	19
Thinking about wellbeing or goals (185)	39	68	74	79
Accessing employment or training (163)	2	9	10	15
None of these (166)	14	16	17	19

Base sizes in parentheses.

Table A2.57: Associates of change in ability to cope with mental health problems between baseline and first follow-up.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
age_30-49	-0.356	-0.533	-0.519	-0.362	-0.481	-0.045	-0.355
	(0.278)	(0.349)	(0.342)	(0.321)	(0.317)	(0.281)	(0.281)
age_50 plus	-0.499	-0.577	-0.644	-0.290	-0.433	-0.379	-0.502
	(0.355)	(0.480)	(0.472)	(0.418)	(0.411)	(0.368)	(0.358)
female	-0.090	-0.121	0.026	-0.090	-0.205	-0.276	-0.099
	(0.221)	(0.340)	(0.290)	(0.270)	(0.241)	(0.218)	(0.223)
non-white	0.107	0.176	0.186	0.123	0.033	-0.045	0.104
	(0.368)	(0.476)	(0.465)	(0.431)	(0.429)	(0.322)	(0.369)
mental health		-					
drugs or alcohol		0.467					
		(0.643)					
homelessness		0.202					
		(0.399)					
domestic abuse		0.593					
		(0.370)					
criminal justice system		0.055					
		(0.382)					
2 disadvantages			0.339				
			(0.681)				
3 disadvantages			-				
4 disadvantages			0.780				
			(0.510)				
5 disadvantages			1.005**				
			(0.494)				

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
contact with substance misuse services				0.574*			
				(0.314)			
contact with domestic abuse services				-0.141			
				(0.381)			
contact with mental health services				0.612**			
				(0.236)			
contact with homeless services				-0.022			
				(0.244)			
contact with probation services				0.110			
				(0.253)			
contact with 2 key services					0.205		
					(0.344)		
contact with 3 key services					0.866**		
					(0.366)		
contact with 4 key services					0.926**		
					(0.452)		
contact with 5 key services					0.462		
					(0.730)		
average caseload						0.043	
						(0.027)	

Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7
No. of support services							0.009
							(0.034)
Constant	1.871***	0.767	0.968	1.455***	1.581***	1.489***	1.829***
	(0.265)	(0.722)	(0.508)	(0.356)	(0.401)	(0.354)	(0.302)
Observations	289	175	175	232	232	289	288
R-squared	0.008	0.044	0.044	0.060	0.051	0.018	0.009

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results.

Table A2.58: Associates of change in key outcomes between baseline and first follow-up.

Getting help with	ReQoL score	Ability to cope without drugs/alcohol	Ability to cope with mental health	Confidence will be in stable accomm	Feeling safe where currently living	Recent experience rough sleeping	Recent experience homelessness	Recent experience domestic abuse	Recent experience criminal justice system	NDTA score
	(1.370)	(0.310)	(0.389)	(0.404)	(0.290)	(0.254)	(0.291)	(0.422)	(0.231)	(1.704)
Setting up bank account	-0.076	0.069	-0.969**	-0.410	-0.779***	0.320	-0.336	0.942***	0.187	3.465
	(1.406)	(0.275)	(0.386)	(0.448)	(0.292)	(0.253)	(0.357)	(0.329)	(0.252)	(1.957)
Help with money problems	0.052	-0.025	-0.031	0.086	0.396	-0.198	-0.219	-0.477	-0.175	1.279
	(1.014)	(0.196)	(0.299)	(0.357)	(0.202)	(0.206)	(0.224)	(0.287)	(0.216)	(1.175)
Budgeting	0.505	0.201	-0.309	-0.614	0.236	0.184	0.566**	0.821***	0.031	-0.626
	(1.152)	(0.240)	(0.343)	(0.443)	(0.237)	(0.225)	(0.229)	(0.296)	(0.233)	(1.248)
Benefits applications	0.003	-0.049	0.429	0.100	-0.121	-0.227	0.115	-0.103	0.224	0.835
	(0.902)	(0.184)	(0.261)	(0.303)	(0.194)	(0.189)	(0.201)	(0.248)	(0.187)	(1.161)
Addressing housing problems	-0.832	0.050	0.149	-0.331	-0.180	0.135	0.014	-0.147	0.060	1.487
	(0.815)	(0.156)	(0.232)	(0.269)	(0.173)	(0.161)	(0.182)	(0.230)	(0.172)	(0.982)
Find or move accomm	1.161	0.031	-0.454**	-0.377	0.335**	-0.053	-0.348	-0.141	-0.082	-1.063
	(0.803)	(0.156)	(0.230)	(0.273)	(0.170)	(0.160)	(0.186)	(0.231)	(0.173)	(0.931)
Making accomm safe	2.427**	-0.044	0.136	0.274	0.317	0.000	0.347	-0.175	-0.092	-1.717
	(1.015)	(0.191)	(0.286)	(0.467)	(0.205)	(0.198)	(0.213)	(0.288)	(0.217)	(1.194)
Police support with violence	-2.741	-0.284	-0.243	-0.153	-0.211	0.147	0.496	0.057	0.103	0.314
	(1.550)	(0.287)	(0.416)	(0.524)	(0.362)	(0.282)	(0.281)	(0.349)	(0.290)	(1.968)

Getting help with	ReQoL score	Ability to cope without drugs/alcohol	Ability to cope with mental health	Confidence will be in stable accomm	Feeling safe where currently living	Recent experience rough sleeping	Recent experience homelessness	Recent experience domestic abuse	Recent experience criminal justice system	NDTA score
Clean/maintain accomm	-1.158	-0.065	0.036	0.567	-0.172	-0.241	-0.404	-0.244	0.335	-0.285
	(1.324)	(0.250)	(0.414)	(0.511)	(0.273)	(0.270)	(0.280)	(0.367)	(0.261)	(1.354)
Attending appointments	0.533	0.360**	0.072	-0.097	0.138	0.191	0.101	-0.068	0.118	-3.092***
	(0.865)	(0.165)	(0.247)	(0.291)	(0.172)	(0.167)	(0.190)	(0.249)	(0.175)	(1.026)
Accessing GP	-0.193	-0.317*	0.048	0.484	-0.392**	0.087	0.200	0.147	-0.336	0.255
	(0.928)	(0.180)	(0.267)	(0.302)	(0.194)	(0.175)	(0.204)	(0.258)	(0.203)	(1.055)
Accessing dentist	2.955**	-0.015	-0.131	-0.590	0.088	-0.336	-0.015	-0.062	0.132	-0.766
	(1.417)	(0.253)	(0.416)	(0.477)	(0.301)	(0.301)	(0.325)	(0.404)	(0.282)	(1.657)
Accessing adult social care	-1.313	0.020	0.550	0.353	-0.248	0.235	-0.278	0.639**	-0.137	-0.065
	(1.163)	(0.235)	(0.336)	(0.405)	(0.246)	(0.219)	(0.280)	(0.280)	(0.242)	(1.446)
Keeping probation requirements	0.296	-0.316	0.231	0.183	-0.225	0.044	-0.744*	0.793***	-0.009	0.216
	(1.220)	(0.242)	(0.347)	(0.362)	(0.266)	(0.235)	(0.400)	(0.291)	(0.239)	(1.390)
Obtaining ID	3.918**	0.965**	-0.546	0.989	1.240***	-0.248	-0.027	-1.324**	0.593*	-0.838
	(1.897)	(0.422)	(0.585)	(0.836)	(0.387)	(0.362)	(0.438)	(0.611)	(0.317)	(2.198)
Legal aid	5.187**	0.846	-1.691**	2.013	-0.475	0.059	0.191	-0.347		1.686
	(2.622)	(0.477)	(0.660)	(1.120)	(0.435)	(0.422)	(0.579)	(0.677)		(3.117)
Understanding your rights	-1.588	-0.318	0.657	-1.286**	-0.165	-0.049	-0.222	0.366	-0.066	3.026
	(1.327)	(0.261)	(0.397)	(0.497)	(0.269)	(0.257)	(0.283)	(0.324)	(0.267)	(1.830)
Introducing you to services	1.366	-0.093	-0.426	-0.334	-0.116	-0.069	-0.215	0.266	0.050	0.990
	(1.042)	(0.195)	(0.287)	(0.368)	(0.209)	(0.204)	(0.236)	(0.278)	(0.211)	(1.312)

Getting help with	ReQoL score	Ability to cope without drugs/alcohol	Ability to cope with mental health	Confidence will be in stable accomm	Feeling safe where currently living	Recent experience rough sleeping	Recent experience homelessness	Recent experience domestic abuse	Recent experience criminal justice system	NDTA score
Introducing you to groups	2.079	0.305	0.433	0.890**	-0.038	0.060	0.525**	0.320	-0.115	-0.377
	(1.133)	(0.224)	(0.314)	(0.411)	(0.228)	(0.227)	(0.242)	(0.280)	(0.239)	(1.470)
(Re)connecting with family	1.366	0.083	-0.106	-0.656	0.605	-0.045	-0.624	0.163	0.586**	-1.112
	(1.645)	(0.321)	(0.501)	(0.553)	(0.366)	(0.316)	(0.424)	(0.404)	(0.278)	(2.052)
Thinking about wellbeing	-0.117	0.001	0.039	-0.028	-0.071	0.034	0.162	0.074	0.310	-0.495
	(0.921)	(0.172)	(0.260)	(0.293)	(0.183)	(0.178)	(0.211)	(0.262)	(0.190)	(1.082)
Accessing employment / training	0.953	0.936**	-0.176	0.823	0.690	0.342	0.756**	0.398	-0.023	-3.766
	(2.012)	(0.475)	(0.571)	(0.718)	(0.394)	(0.376)	(0.361)	(0.459)	(0.394)	(2.511)
Other	1.594	0.492	-0.364	-0.499	0.261	0.223	0.084	0.326	-0.019	0.194
	(1.500)	(0.277)	(0.420)	(0.478)	(0.349)	(0.280)	(0.317)	(0.435)	(0.371)	(1.921)
Constant	0.279	-0.297	1.938***	1.328***	-0.345	-1.099***	-1.183***	-1.580***	-1.232***	-3.123**
	(1.186)	(0.234)	(0.350)	(0.407)	(0.243)	(0.213)	(0.250)	(0.321)	(0.215)	(1.344)
Observations	375	283	288	127	254	496	483	390	484	325
R-squared	0.153	0.158	0.110	0.239	0.196					0.105

Standard errors in parentheses. ***p<0.01, **p<0.05. See pages 83 to 86 for further information on the regression analysis and interpretation of results. See Table A2.56 for an indication of the proportion of participants receiving different types of support.

Appendix 3: Partners survey data table

Table A3.1: Have you received any training related to trauma-informed practice?

Received trauma-informed practice training	Frequency	Percent
Yes	227	80.8
No	46	16.4
Not sure	8	2.8
Total	**281**	**100**

Table 3.2: How long ago did you receive this training?

When received training	Frequency	Percent
Within the last 12 months	135	59.5
1–2 years ago	66	29.1
3–4 years ago	16	7
5 or more years ago	8	3.5
Not sure	^	^
Total	**-**	**-**

^ indicates where values have been suppressed due to counts of <5

Table A3.3: Does your organisation share client records, data management or information systems with other organisations involved in the local system?

Does your organisation share information?	Frequency	Percent
Yes, with multiple organisations	282	57.7
Yes, with a single organisation	41	8.4
No	95	19.4
Don’t know	65	13.3
Not applicable	6	1.2
Total	**489**	**100**

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