Evaluation of the MEAM pilots

An interim report by FTI Consulting and Compass Lexecon for Making Every Adult Matter (MEAM)

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Terms of reference

Making Every Adult Matter ("MEAM") has asked FTI Consulting LLP ("FTI Consulting") and Compass Lexecon to perform an evaluation of three service pilots in Cambridgeshire, Derby and Somerset. We were introduced to MEAM by Pro Bono Economics ("PBE").

This report summarises the work performed by the pilots and the results of our evaluation. Our evaluation is based upon information provided by MEAM and by the pilots. We have also drawn upon interviews with pilot coordinators, local service providers and pilot clients conducted in January 2012 by Babcock Research ("Babcock"), a social research agency.

This report is accompanied by a Technical Appendix. The Technical Appendix explains our methodology in greater detail for the interested reader.

This report has been peer reviewed by Grant Fitzner, Director of Analytics at the Centre for Workforce Intelligence, and we are grateful for his comments, advice and insights.

Disclaimer

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Introduction

Across the country there are approximately 60,000 people facing multiple needs and exclusions. These individuals experience multiple problems such as homelessness, substance misuse, mental health problems and offending. Their multiple needs mean that they have ineffective contact with services and that they live chaotic lives at the margins of our communities. This results in significant costs for them and for wider society.

Eighteen months ago, Making Every Adult Matter (MEAM) began to support three pilot programmes to improve coordination of existing local services for this group. The pilots were based on four core elements taken from previous multiple needs programmes – coordination, flexibility, consistency and measurement.

Each pilot employed a coordinator to engage with clients, build trust and ensure the best possible route through existing services, for example by helping clients to gain access to housing, treatment for substance misuse, or mental health assessments. Coordinators were supported by an Operational Group and Board of local services, which helped to ensure strategic engagement and enable all local agencies to provide flexible responses for clients.

Measurement has been an important element of the pilots as it shows the effect that a coordinated approach can have on clients' wellbeing and service use. PBE, FTI Consulting and Compass Lexecon have helped MEAM to perform a rigorous economic evaluation of the pilots. In this report, we summarise the results of that evaluation.

During our study the pilots worked with the most excluded individuals in their local areas. Our evaluation considers the 39 clients who were enrolled in the programme in at least three consecutive calendar months and who gave their consent to participate in our study. On average, these clients participated in the pilot for seven months.

Overview of findings

MEAM expected that the pilot programme would have two main effects:

(1) Clients' wellbeing would improve, both in the short-term as they addressed their most urgent and severe problems such as rough sleeping or substance misuse; and in the longer-term as they started to lead more stable lives.

(2) Clients' service use would change, with less use of expensive emergency services (such as the police and A&E) and an increase in cheaper, planned interventions. Although MEAM expected an initial increase in costs as people got the help they needed, it hoped that costs would eventually decrease as clients made more effective use of services.

Our findings show that the pilots have already had a very positive effect on clients' wellbeing. We observed significant improvements for nearly all clients across three quantitative wellbeing measures. These measures reflected factors such as clients' general satisfaction with their lives, their standard of health, their ability to manage tenancies and their ability to tackle problems such as substance misuse and offending behaviour.

We also observed changes in clients' service use. Some service use costs decreased in this first year of the pilot. For example, after enrolment in the pilot, clients in Cambridgeshire were less frequently cautioned, arrested, required to attend court, or spend time in police custody. As a result, the costs incurred by the criminal justice system in relation to the Cambridgeshire clients decreased. There was a similar reduction in criminal justice costs in Somerset. In Derby, criminal justice costs did not decrease overall, although they might in the future as the clients' lives become more stable.

Some costs increased in the first year of our study. Many clients were homeless, in poor health and suffering from a number of other problems when they enrolled. The costs of providing housing, medical treatment and help with substance misuse have increased in the short-term, as we expected they might.

In Cambridgeshire, the reduction in crime costs (£100,000 or 31%) was large enough to offset the increases in other cost categories resulting in an overall cost reduction. The total costs of service use in the first year increased in the other two areas.

These results may be linked to the fact that the pilot areas intentionally selected the individuals in their local area with the most severe multiple needs. Many individuals in the client group have experienced severe problems over many years and it can take a long time to help these clients change their service use. In addition, the costs of an initial intervention can be high. We will continue to follow the 39 clients in this study for a further year to see how their service use evolves, and report on progress in 2013.

This report

This report is divided into four sections:

(1) an introduction to MEAM and the pilots;

(2) the results of the evaluation;

(3) tips for areas considering coordinated interventions; and

(4) appendices and technical information.

This report will be of interest to local and national policymakers and is relevant to the development of coordinated services in other local areas. The service use data collected is some of the strongest available on multiple needs and exclusions. MEAM and the pilot areas are pleased that they have submitted their interventions to rigorous analysis and PBE, FTI Consulting and Compass Lexecon are pleased to have been able to offer their support and expertise.

We finish with a quote from one of the pilot clients: [1]

> *"Since he got on my case, things have taken a turn for the good. Before I was going round in circles. It's not a bed of roses yet, but before it was a dead-end."*

Oliver Hilbery, MEAM
Sue Holloway, PBE
Boaz Moselle and Tim Battrick, FTI Consulting
Kirsten Edwards, Compass Lexecon

[1] Source: Interviews conducted with clients by Babcock. Coordinator name has been removed as interviews were conducted anonymously.

What are multiple needs and exclusions?

MEAM uses three criteria to identify people facing multiple needs and exclusions:[2]

1. They experience several problems at the same time, such as homelessness, substance misuse, mental ill health and offending. They may have one main need complicated by others, or a combination of lower level issues that together are a cause for concern. These problems often develop after traumatic experiences such as abuse or bereavement. Adults facing multiple needs live in poverty and experience stigma and discrimination.

2. They have ineffective contact with services. People facing multiple needs usually look for help, but most public services are designed to deal with one problem at a time and to support people with a single, severe condition. As a result, professionals often see people with multiple needs (some of which may fall below service thresholds) as 'hard to reach' or 'not their problem'. For the person seeking help this can make services seem unhelpful and uncaring. In contrast to when children are involved, no one organisation takes overall responsibility.

3. They live chaotic lives. Facing multiple problems that exacerbate each other, and lacking effective support from services, people easily end up in a downward spiral of homelessness, substance misuse, mental ill health and offending. They become trapped, living chaotic lives where escape seems impossible, with no one offering a way out.

How many?

MEAM estimates that there are approximately 60,000 adults in this situation at any one time in England.[3] While relatively small in number, this group impose disproportionate costs on government and society.

2 MEAM and Revolving Doors Agency (2011), *Turning the Tide: A vision paper for multiple needs and exclusions*, MEAM/RDA, page 4.

3 MEAM (2009), *A four-point manifesto for tackling multiple needs and exclusions*, page 8.

What are the MEAM pilots?

MEAM has supported three pilot areas to improve the coordination of existing services for people facing multiple needs and exclusions. The three pilots aimed to show that, with a small investment in the coordination of existing local services, coupled with flexible responses from mainstream agencies, areas could significantly improve outcomes for their most excluded individuals and deliver value for money.

Each pilot was based on four core elements taken from previous multiple needs programmes. These are:

1. Coordination: Each pilot employed one full-time or two part-time coordination workers, who engaged with individual clients in order to build trust and ensure the best possible route through existing services.

2. Flexibility: Each pilot area set up Boards and Operational Groups with representatives from relevant statutory and voluntary partners. These met regularly to oversee the service, ensure strategic engagement, provide a forum for case management and enable local agencies to provide flexible responses for this group.

3. Consistency: The New Directions Team ("NDT") Assessment© [4] (sometimes referred to as the 'Chaos Index') helps identify individuals facing multiple needs and exclusions. By focussing on behaviours and the level of engagement with services, the assessment helped each pilot to choose a caseload of similar clients.

4. Measurement: Each pilot collected data on client wellbeing and service use, which they have provided to us for this evaluation. Babcock, a social research agency, performed additional qualitative research, interviewing 17 clients, 12 service coordinators/project leads and 13 partner agencies.

The three MEAM pilots were located in Cambridgeshire, Derby and Somerset. The pilots started in December 2010/ January 2011 and lasted for one year. In all three areas, further funding was found to keep the pilots running in early 2012 and, at the time of writing, all three have confirmed funding (one with slight service changes) for at least part of 2012/13.

Appendix 2 shows the organisations involved in each area.

[4] The NDT Assessment framework was developed by South West London and St George's Mental Health Trust and its partners as part of the Merton Adults Facing Chronic Exclusion pilot and uses a set of behavioural indicators to define individuals facing multiple needs and exclusions. A copy of the NDT Assessment questions is shown in Appendix 3. Any area using the NDT Assessment framework in full or in part must acknowledge copyright to the South West London and St George's Mental Health Trust.

Who were the clients?

Clients were referred to the pilots by local agencies and then accepted based upon their NDT scores. We asked each pilot area to use the NDT Assessment as a tool to identify the most chaotic individuals in their local area, rather than those they felt would be easiest to work with.

During the twelve months of our study, the pilot areas worked with 69 clients. We have included 39 of those clients in our analysis for this evaluation (see page 8 for details).

Clients came from a wide range of backgrounds. Twice as many clients were male as female and ages ranged from 19 to 62 with an average age of 39.

Information collected on the clients' backgrounds was self-reported. This information showed that, as expected, all clients suffered from multiple needs. We considered the proportion of clients who had, at some point, been homeless, used drug or alcohol services, used mental health services or spent time in prison. 43% of clients reported to have experienced all four before participating in the programme and 76% at least three.

At the time of enrolment, nearly 80% of clients were homeless, 56% were currently involved with drug or alcohol services and 44% involved with mental health services. Only a minority were currently in prison but 81% had been to prison previously.

Clients' needs had often started at a young age and it was clear that traditional service provision had failed to get these individuals 'on track' despite lengthy involvement.[5]

Statistics for clients who have previously used services

	Average age of first involvement	Average length of involvement for those still using the service
Homelessness services	23	9 years
Drug or alcohol services	19	7 years
Mental health services	15	8 years
Prison / offender services	23	12 years

Note (1): Between 35 and 37 clients answered each question regarding the age at which they first used certain services.
Note (2): Between 31 and 33 clients answered each question regarding their length of involvement with certain services.
Source: Self-reported data.

A notable proportion of clients had been in care as a child (36%) and often for a significant period of time with the average period being eight years.

[5] These statistics paint a similar picture to the findings of Fitzpatrick, Bramley and Johnsen (2012), *Multiple Exclusion Homelessness in the UK: An Overview of Key Findings, Briefing paper No. 1.*

When joining the programme, participants tended to:[6]

- **be in relatively poor health:** 35% of clients initially rated their health as “bad” or “very bad”;
- **be unemployed:** only one client was employed at the start of the pilot, the remainder were unemployed or unable to work;
- **receive benefits:** 92% of clients stated that benefits were their main source of income;
- **consume large quantities of alcohol:** participants estimated that they consumed an average of 133 units of alcohol each week – more than six times the recommended weekly intake for a man; and
- **be victims of crime:** 48% reported being a victim of crime in the previous three months.

Appendix 5 shows an example of the initial questionnaire that clients completed.

Qualitative data

In addition to this data, Babcock carried out interviews with five or more clients in each area to help us understand how clients had come to participate in the programme and why they needed the help of a service coordinator.

Only one client did not want to talk about their past life. The remainder described lives of homelessness and, for many, alcoholism, drug addiction, being in trouble with the police and behavioural and anger problems. Most clients had spent time in prison (often multiple times) and several suffered from mental health problems.

Several clients pointed out that their problems meant they fell into a group that was difficult for services to help. Many suggested that they previously had no hope for the future and some had contemplated suicide.

[6] These statistics are based on samples of between 26 and 37 individuals depending upon the number answering the relevant question.

How did the pilots help clients?

The most visible way in which the pilots helped clients was through the service coordinator. However, the Boards and the Operational Groups in each area also made important contributions.

Service coordinators

Service coordinators engaged with clients to build their trust and ensure the best possible route through existing services. The role of the coordinator was very 'hands-on'. Having one person deliver information to the client from different agencies meant that it was easier for clients to navigate local services. Interviews show that the continuity of the relationship with the coordinator was important to clients because it meant that they did not need to explain their circumstances and life history repeatedly.

It is hard to list everything that service coordinators did for clients. One client stated:

> *"She takes me to appointments, she's helping me get my own flat, she's helping me to get contact with my kids, helped me with violence, alcohol, and she's saving my life by helping me get to the hospital for chemotherapy...She's helped me a hell of a lot."*

One coordinator explained:

> *"We are the clients' everything: We do face to face meetings; liaison; getting agencies to flex; helping people to paint their flats; getting community care grants; food parcels; chasing for these grants; representing people in court; pre-sentence reports; taking them where they need to be…"*

The Boards and Operational Groups

The Boards and Operational Groups provided forums to drive strategic engagement, discuss ways in which frontline agencies could work together, and agree specific approaches to individual clients. This made it possible for services to offer assistance to clients that was personalised to their needs. Sometimes this meant finding flexible new ways of delivering services. Interviewees explained that:

> *"At the Board the agencies are working together….people have been able to make things happen."*

> *"It's [the Operational Group] been even better than the Board for [co-ordinator] in dealing with barriers for specific clients."*

See the section "Tips for setting up a coordinated service" (page 21) for more details about the role of coordinators, Boards and Operational Groups.

Evaluation overview

In total, the pilots worked with 69 individuals. Of these, we include in our evaluation the 39 clients who participated in the programme for at least three consecutive calendar months and who provided consent.[7]

MEAM expected that the pilot programme would have two main effects:

(1) Clients' wellbeing would improve, both in the short-term as they addressed their most urgent and severe problems such as rough sleeping or substance misuse; and in the longer-term as they started to lead more stable lives.

(2) The profile of clients' service use costs would change, with less use of expensive emergency services (such as the police and A&E) and an increase in cheaper, planned interventions. Although MEAM expected an initial increase in costs as people got the help they needed, it hoped that costs would eventually decrease as clients made more effective use of services.

Over the following pages we present our findings regarding wellbeing and service use. We explain what we did and what we found. We also explore some of the differences between the pilot areas.

[7] Fifty four of the 69 clients were enrolled in the pilot for at least three consecutive calendar months. Of these, 39 gave consent to participate in our study. The number of clients in the evaluation (and the total number of clients worked with) in each pilot area was as follows: Cambridgeshire: 15 (20); Derby: 13 (31); Somerset: 11 (18). Of the 15 clients who did not consent, ten were enrolled in the Derby pilot. A change was made to the Derby consent form after the pilot had started, at which time some of these clients were no longer in contact with the service. We do not consider that the requirement to provide consent introduced a selection bias into our results.

Client wellbeing: What we measured

We wanted to understand the effect of the pilots on client wellbeing. We asked service coordinators to collect wellbeing data using three measures:

- **The NDT Assessment:**[8] This assessment is completed by the service coordinator and scores the client's behaviour across ten areas. This includes the level of engagement with frontline services, the risk of self harm and the extent of alcohol and drug abuse.
- **The Warwick-Edinburgh Mental Well-Being Scale© ("WEMWBS"):**[9] The WEMWBS questionnaire is completed by the client and measures fourteen aspects of their mental wellbeing.
- **The Outcomes Star™:**[10] The service coordinator and client completed the Outcomes Star™ homelessness questionnaire together to measure the client's progress towards goals such as maximising their independence.

This data was collected as soon as possible after each client enrolled with the programme and again at the end of the pilot (or when the client was discharged from the pilot if before). The average span was nine months for all three questionnaires.

8 The NDT Assessment framework was developed by South West London and St George's Mental Health Trust and its partners as part of the Merton Adults Facing Chronic Exclusion pilot and uses a set of behavioural indicators to define individuals facing multiple needs and exclusions. A copy of the NDT Assessment questions is shown in Appendix 3. Any area using the NDT Assessment framework in full or in part must acknowledge copyright to the South West London and St George's Mental Health Trust.

9 The Warwick-Edinburgh Mental Well-Being Scale was funded by the Scottish Executive National Programme for improving mental health and well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh. A copy of the Warwick-Edinburgh Mental Well-Being Scale is shown in Appendix 9.

10 The Outcomes Star™ is a suite of tools for supporting and measuring change when working with vulnerable people. There are 14 versions of the tool, including the homelessness star used in MEAM pilots. The Outcomes Star™ was developed by Triangle Consulting Social Enterprise Limited. Further information is available at http://www.outcomesstar.org.uk. A copy of the Outcomes Star™ is shown at Appendix 10.

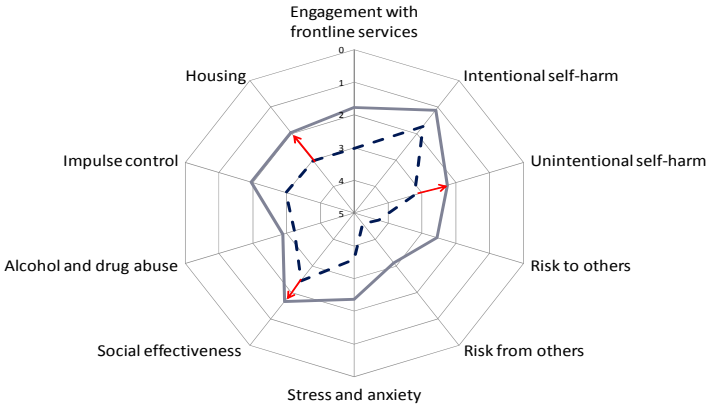
Client wellbeing: Findings

All three wellbeing measures show that in most cases both clients and service coordinators observed an improvement in wellbeing.[11] The findings around wellbeing were similar across all three pilot areas. The diagrams below present our findings for the clients in all pilot areas. Appendices 11, 12 and 13 show the results for individual pilot areas.

Change in average NDT scores

This diagram shows the average improvement in NDT scores for the 36 individuals for whom we were able to collect data.

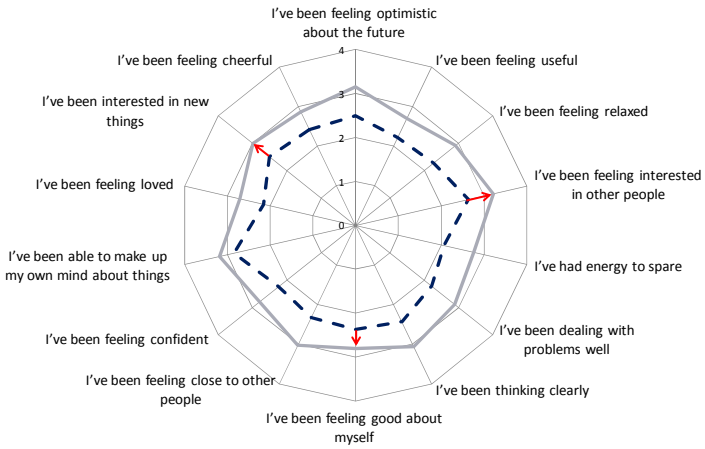
(All scores are out of 4, except "Risk to others" and "Risk from others", which are out of 8).



Change in WEMWBS

This diagram shows the average improvement in WEMWBS scores for the 33 individuals for whom we were able to collect data.

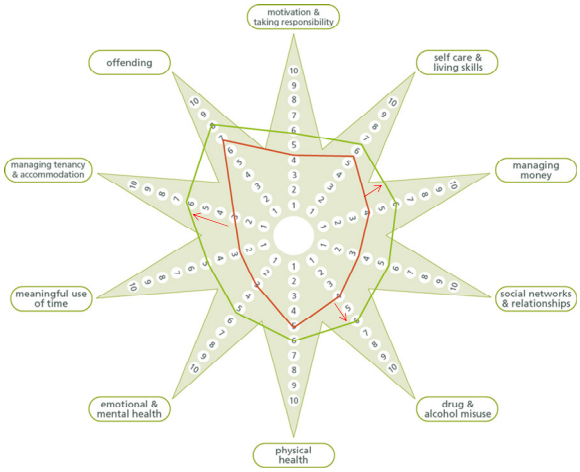
(All scores are out of 5).



Change in average Outcomes Star™ scores

This diagram shows the average improvement in Outcomes Star™ scores for the 31 individuals for whom we were able to collect data.

(All scores are out of 10).



[11] It was not possible to collect endpoint data for some clients. Where this was the case, we excluded these clients from the relevant part of our analysis. The number of clients for whom data is shown is indicated next to each graph. The Technical Appendix presents a more detailed discussion of our methodology.

Client wellbeing: More detail

All three wellbeing measures show that in most cases both clients and service coordinators observed an improvement in wellbeing:[12] [13]

- average NDT scores improved from 32 to 22;
- average WEMWBS scores improved from 33 to 41; and
- average Outcomes Star™ scores improved from 42 to 60.

Most (but not all) clients showed an improvement on all three scales. One client showed a worsening of their situation against all three, though there were specific reasons for this.

The final (second) questionnaires were completed in the weeks leading up to the end of the pilot. On average, the final questionnaires were completed nine months after the initial questionnaires. Many of the clients remained in the service at the time of the second questionnaire and may have experienced further improvements in wellbeing after we collected this data.

The positive results of our analysis are supported by the information collected in interviews with clients and service coordinators. These show that the changes in clients' lives that have come about because of engagement with the pilots are significant. They include: being housed, having help with anger management or substance misuse, being supported through interactions with physical health services and court appearances and so on. Two clients described their stories as follows:

> *"If you could take a picture of me 12 months ago and one of me now, you would see an enormous contrast."*
>
> *"She makes me think before I act, people tried before…but she does it bit by bit…Now I can step outside myself and I can understand my trigger points. She's learned me self-confidence without drinking."*

In some cases, clients are still working to overcome their problems, but for these clients the main change in their lives is that they now feel that they have someone on their side to support them; that something tangible and positive has happened in their lives for the first time in a long while; and that they have hope for the future:

> *"I've got hope to build a future."*
>
> *"You only survive [before], but now I've got something to live for."*

Apart from talking about having homes, stability and hope, clients talked about new aspects of life opening up to them. These new avenues of endeavour, suggested and supported by coordinators, provided clients with new social connections and community support as well as areas of interest that draw their focus away from destructive behaviours and habits.

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[12] For the NDT scores, a lower number indicates greater wellbeing. For the WEMWBS and Outcomes Star scores, a higher number indicates greater wellbeing.

[13] Those improvements are statistically significant at the 1% level under a Wilcoxon matched pairs signed rank test. We explain our statistical analysis in the Technical Appendix.

Babcock asked clients about their future plans and expectations. Most were extremely positive, and some were positive while being realistic about the hard work that might lie ahead. Some clients were hoping to study for qualifications; others were pre-occupied with the need to either arrange or maintain housing arrangements. Most clients were clear about their next steps.

> *"Without [co-ordinator], I would most probably be homeless and in a bad situation, drinking heavily, committing crime."*

> *"I want to settle down, I have never had a settled life. I want to get a job, meet somebody, you know…"*

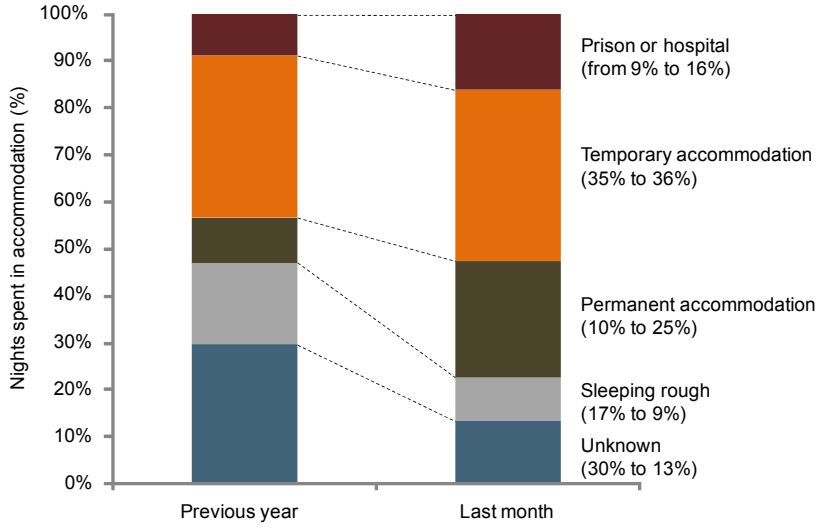
Local agencies also observed significant progress by clients, citing examples of clients' changed circumstances, of their improved physical and mental wellbeing and of increased hope and motivation. It was also reported that in some cases clients' peers were interested in becoming involved in the pilot programme.

The effect of housing on wellbeing

Homelessness was the most common need across the client group and we include an analysis here because of its effect on wellbeing. Both the NDT and Outcomes Star™ measures show an improvement in clients' housing situations. We also collected data on clients' housing situations throughout the pilot period. In the year prior to enrolment, clients spent 17% of nights sleeping rough. In the last month of the pilot, this had decreased to 9%. Figures for permanent accommodation increased from 10% to 25%.

The graph below shows the proportion of clients sleeping in different types of accommodation. The first bar represents the situation in the year prior to enrolment and the second bar represents the situation in the final month in which we collected data.

In this graph below, we classify sleeping at the home of friends and family as temporary accommodation. We reserve the rough sleeping category for those sleeping in the open air or in buildings not designed for habitation, such as car parks or stations.



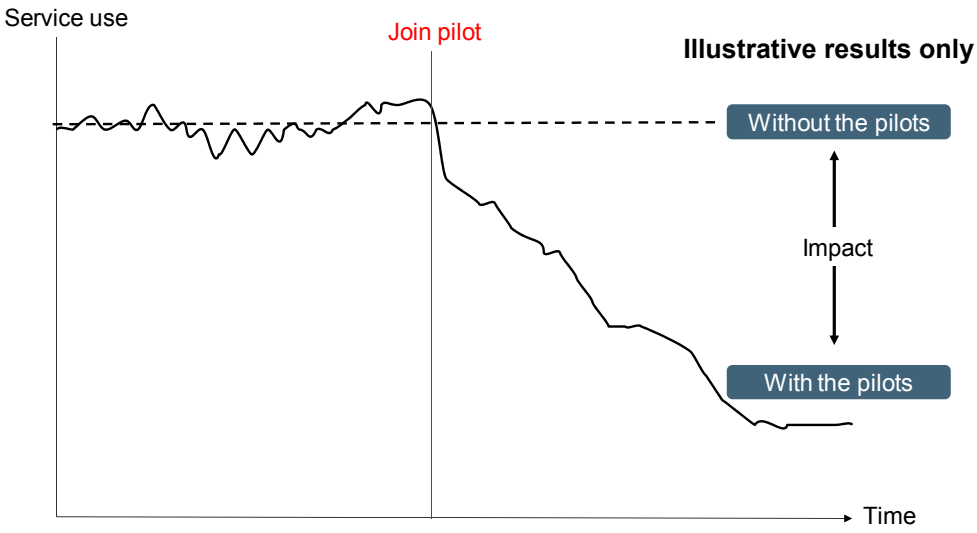
Service use: What we measured

We sought to understand which services clients used and how their service use changed after enrolment in the pilot programme.

We collected monthly data direct from local services, including each client's:

- involvement with the criminal justice system (such as arrests);
- use of health and mental health services (such as A&E attendances);
- use of drug and alcohol services (such as treatment programmes); and
- housing situation (such as the use of hostels).

We collected similar data for the year prior to enrolment and we use this as a 'baseline' to estimate clients' service use had they not participated in the pilot. This methodology is summarised in the diagram below and further detail is available in the Technical Appendix.



To determine the effect of the pilot, we compare clients' service use after joining the pilot with our estimate of their service use had they not participated. Some clients joined after the pilot had begun. For these clients, we have less than twelve months of post-enrolment data. In this case we compare post-enrolment service use to the relevant proportion of service use in the previous twelve months.

An example of the questionnaire we used to collect service use data is shown in Appendix 6.[14]

Using published unit costs we have calculated the cost of providing the services used by each client before and after their enrolment with the pilot. These unit costs are shown in Appendix 7.

All clients gave their consent for the relevant information to be collected directly from local services and so we do not rely on self-reported data for this part of our analysis.

[14] We were not provided with data on all types of service use from all areas. The data not provided was: data on the use of mental health services in Somerset, data on the use of criminal justice services in the last six months of the Somerset pilot and probation data for Cambridgeshire.

Service use: Findings

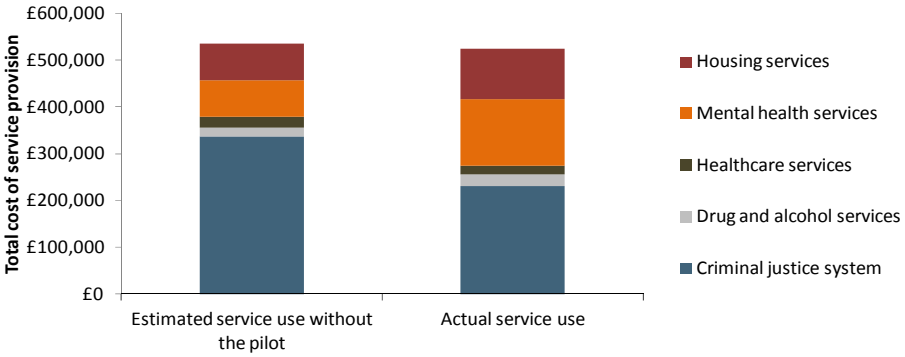
The graphs below compare:

(1) the total cost of providing services to clients after enrolment in the pilot (and, if they were discharged, the period after they left); and

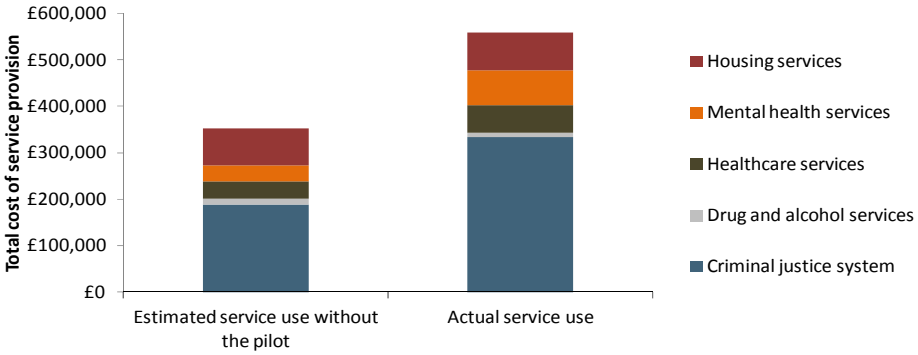
(2) our estimate of the cost of service provision over the same period had clients not enrolled in the pilot.

Appendix 8 shows the data included in these graphs at a more detailed level. The average client participated in the pilot for seven months. Because we also have data for clients discharged from the pilot, the average period of data that we have after enrolment is slightly longer, at nine months.

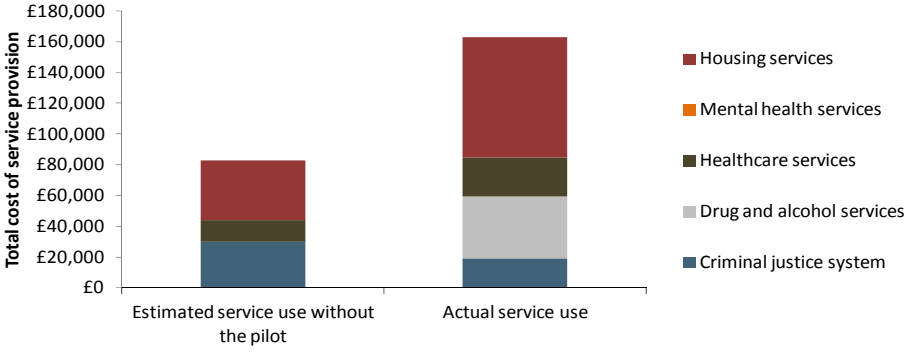
Cambridgeshire: Effect of the pilot on the total cost of service use (n=15)



Derby: Effect of the pilot on the total cost of service use (n=13)



Somerset: Effect of the pilot on the total cost of service use (n=11)



Note: Somerset offending data for the last six months and mental health data could not be collected so not included.

Cost of service use per month for the average client

The graphs above show that the total level of costs varies significantly between the pilot areas. This is due to differences between the areas in terms of service use patterns, the number of clients, the average time of enrolment and data availability.

To separate the differences in service use patterns from the other factors, we have considered the cost of service use per month for the average client in each area, both before and after enrolment. The tables below show our analysis.

Cambridgeshire: Average monthly cost of service provision before and after enrolment

	Estimated cost per month		Monthly cost	
	without enrolment £	with enrolment £	increase / (reduction) £	Percentage change
Recorded offending	2,232	1,542	(689)	(31)%
Health and mental health	659	1,055	397	+60%
Drugs and alcohol	132	168	36	+27%
Housing	521	710	189	+36%
Total	**3,544**	**3,475**	**(68)**	**(2)%**

Derby: Average monthly cost of service provision before and after enrolment

	Estimated cost per month		Monthly cost	
	without enrolment £	with enrolment £	increase / (reduction) £	Percentage change
Recorded offending	1,567	2,762	1,195	+76%
Health and mental health	592	1,099	507	+86%
Drugs and alcohol	95	79	(16)	(17)%
Housing	657	672	15	+2%
Total	**2,911**	**4,612**	**1,700**	**+58%**

Somerset: Average monthly cost of service provision before and after enrolment

	Estimated cost per month		Monthly cost	
	without enrolment £	with enrolment £	increase / (reduction) £	Percentage change
Recorded offending	860	544	(315)	(37)%
Health	136	240	105	+77%
Drugs and alcohol	0	405	405	N/A
Housing	394	785	391	99%
Total	**1,390**	**1,975**	**585**	**42%**

Note on the cost of benefits: The housing category includes the cost of housing benefits. The cost of other benefits is not included in this analysis because benefit data was not available in all three areas. Our analysis of benefits data that we could collect indicates that there was no material change in the level of benefits claimed before and after enrolment.

Service use: More detail

Our findings show that the overall cost of service use decreased after enrolment in the Cambridgeshire pilot but increased in the other two pilot areas.

As clients have gained access to services, some costs have inevitably increased. MEAM had hoped that these costs would be offset by reductions in inappropriate service use such as arrests. This was the case in Cambridgeshire, where criminal justice costs decreased by £100,000 (31%) and these savings more than outweighed the increases in health, drug and alcohol, and housing costs incurred to help clients address their multiple needs.

While there was an overall reduction in service use costs in Cambridgeshire, this was not the case in the other two pilot areas. In Somerset, crime costs fell, but not by enough to outweigh the increased costs of providing other services. In Derby, crime costs themselves rose, driven partly by some clients whose offending increased significantly upon entering the pilot.

Cost increases occurred for two reasons. First, some clients' costs increased as they gained access to services from which they were previously excluded. This is a positive outcome, even though it has a cost associated with it. Examples include clients who were able to address their health and addiction problems, and clients who had previously been rough sleeping but who now have access to housing. One coordinator provided the following example:

> *"One client was living in a tent…eating out of skips, no benefits. He didn't cost anything. Then we come in…and he will be more expensive."*

Second, some clients' costs increased for less positive reasons. An example is the increase in crime costs observed in Derby.

The pilots intentionally selected the individuals in their local area with the most severe multiple needs. Many individuals in the client group had highly entrenched problems and it can take a long time to help these clients change their service use. It is possible that the clients in the Derby and Somerset pilot areas need a longer period of engagement (than the average seven months of enrolment in this study) to result in an overall reduction in costs.

Had the pilots been able to work with more clients, with slightly less chaotic lives on average, then a faster change in service use may have been observed, resulting in greater cost savings.

Variation between pilot areas

It is clear from the tables above that individuals experiencing multiple needs and exclusions have a significant cost effect on local services, with monthly costs for the average client varying from £1,400 in Somerset to £3,500 in Cambridge. However, the tables also show that the level of service use costs varied significantly between the pilot areas.

For example, all costs were lower in the year before enrolment in Somerset than in the other two pilot areas. This is likely to relate to differences between the three areas. For example, Somerset clients tended to be arrested less frequently, perhaps because their behaviour had less of an effect on others in this relatively rural location. The effect of the pilot on other cost categories also varied between areas. For example, housing costs remained reasonably constant in Derby, but almost doubled in Somerset, where initial housing costs had been much lower.

Effect of outliers

Following enrolment in the pilots, some clients changed their service use in very different ways to others. The table below shows, for each pilot area, the number of clients whose costs in each category increased and the number whose costs decreased.

Analysis of the number of clients showing cost increases and savings by service category

	Cambridgeshire		Derby		Somerset	
	Decrease	**Increase**	**Decrease**	**Increase**	**Decrease**	**Increase**
Recorded offending	8	3	3	9	1	2
Health	3	3	2	4	0	2
Drugs and alcohol	0	3	2	1	0	1
Housing	3	6	6	5	1	3
Overall	**8**	**7**	**2**	**10**	**1**	**6**

Note: Where service use changes in a category are minimal (less than £1,000 in total over the pilot), we exclude that client from the relevant row. This table therefore shows only meaningful changes in service use.

Some of the results in the graphs and table above are affected by a few "extreme" cases ("outliers"). For example, one client achieved a cost saving of £10,000, even after accounting for the additional £19,000 cost of his accommodation. The greatest cost increase was for a man whose offending increased significantly after enrolment. His costs increased by £69,000, mainly due to an increase in the number of times he was arrested. One possible reason for this could be that he spent significantly less time in prison during the pilot compared to the previous year.

If we want to forecast how the programme might work if extended to more clients in the same areas or more geographic areas, then it may be misleading to consider these outliers.

Our analysis of outliers illustrates two things:

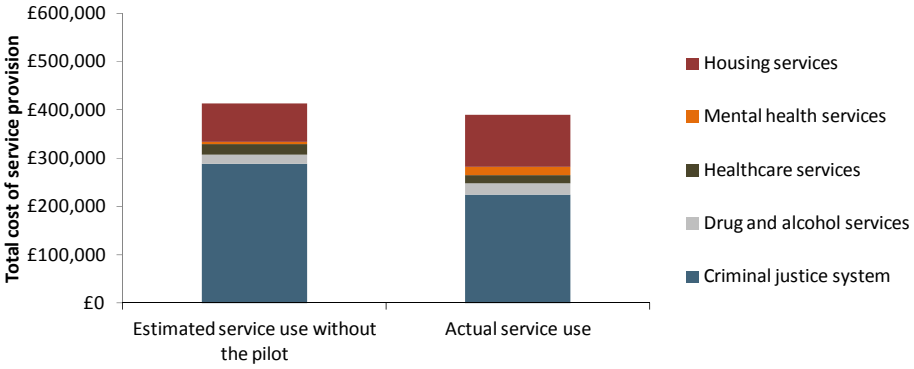
(1) there are significant differences in the costs associated with different clients; and

(2) service use for some clients varies significantly from month to month, for example service use costs can be significant in months in which clients are arrested, imprisoned or attend court.

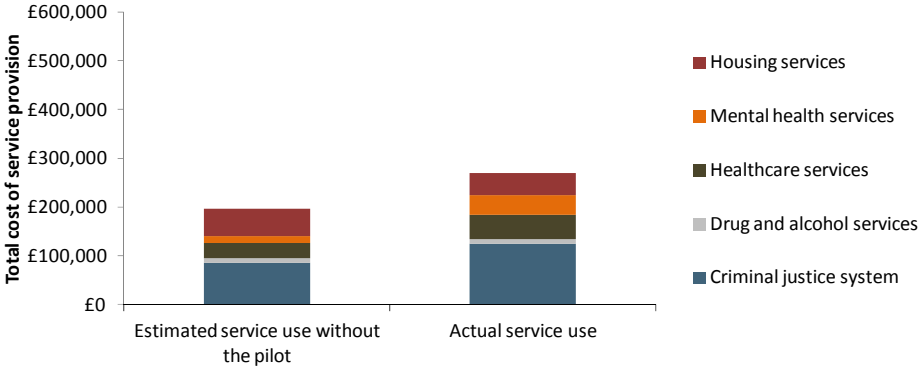
The graphs below repeat those on page 14 removing the following outliers:

- in Cambridgeshire, the one client who had an extended stay in a mental health hospital;
- in Derby, the four clients whose offending increased significantly upon entering the pilot; and
- in Somerset, the one client who spent an extended period in a residential rehabilitation centre.

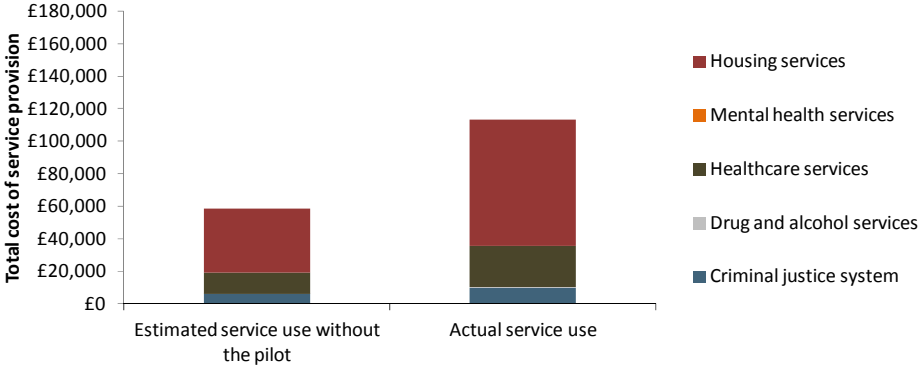
Cambridgeshire: Effect of the pilot on the total cost of service use, after removing one outlier (n=14)



Derby: Effect of the pilot on the total cost of service use, after removing four outliers (n=9)



Somerset: Effect of the pilot on the total cost of service use, after removing one outlier (n=10)



Cost of running the pilots and their economic effectiveness

The total cost of running the pilots was relatively low because their focus was on better coordination of existing services, rather than the provision of entirely new services. The cost to run the pilot for twelve months was £58,000 in Cambridgeshire, £34,000 in Derby and £68,000 in Somerset. These amounts include the salaries of the coordinators in each area, a 'flexible needs pot' to be spent on clients as required, and the direct and indirect costs associated with facilities such as office space. Management time was not always included.

An analysis of the economic effectiveness of the pilots must consider both the cost of running the pilots as well as their effect on service use. In the case of the Derby and Somerset pilots, the cost of running the pilots added to the increased costs of service use. In the case of the Cambridgeshire pilot, where service use costs reduced, the cost of running the pilot is still approximately £47,000 greater than these cost savings.

As a result, none of the pilots resulted in an overall cash saving over the period of our study. However, this cash figure does not reflect all positive outcomes observed, such as the decline in rough sleeping, the increase in client wellbeing. Nor does it reflect future savings that may result if positive changes in service use continue.

Why we chose our approach

All the individuals we tracked in our study participated in the pilot programme. Our analysis is based upon a comparison of wellbeing and service use before and after enrolment in the pilot.

Some other programme evaluations adopt a control group approach. Control group studies also track a group of individuals who do not participate in the programme being evaluated. The control group's behaviour is tracked to determine whether there are factors other than the pilot that might have caused the clients' behaviour (here wellbeing and service use) to change over time.

It was not feasible to involve a control group in our study for two reasons.

First, use of a control group raised ethical concerns, since having a control group would have meant identifying qualifying individuals and then excluding them from participating in the programme. Clients were instead chosen from the individuals experiencing multiple needs of which each pilot area was aware. Pilot areas did not randomly select clients but instead selected those that they deemed to have the most serious multiple needs.

Second, using a control group would have been difficult from a practical perspective. Adults with multiple needs tend to have chaotic lifestyles. It can therefore be difficult to keep track of these individuals when they are not enrolled in a programme.

In our view, it is reasonable to assume that clients' levels of wellbeing and pattern of service use would have remained roughly constant had they not enrolled in the programme because:

(1) the individuals in the client group have typically had multiple needs for a long period of time and been involved with local services in an attempt to address those needs for a long period of time (see page 5). The failure of existing services to adequately address clients' multiple needs suggests that these needs would probably have continued had they not enrolled in the pilot.

(2) work by organisations such as Revolving Doors Agency[15] and the previous government's Adults Facing Chronic Exclusion Programme[16] indicates that adults with multiple needs become trapped in an ongoing cycle from which there is no easy escape. These studies show that individuals in this situation are likely to require specific help to change their behaviours.

(3) when asked about the effect of the pilot on their lives, clients stated that their situation would likely have deteriorated further without help from the pilots.

We discuss our methodology and the issue of control groups further in the Technical Appendix.

[15] Revolving Doors (2010), *Why multiple needs should be a key consideration in the development of the "rehabilitation revolution" Green Paper and subsequent reforms*.

[16] Cattell and Mackie (2011), *Simple but effective: Local solutions for adults facing multiple deprivation*, Communities and local Government.

Tips for setting up a coordinated service

When asked whether the MEAM model is transferable to other locations, one of the project leads stated:

> *"The pilot is transferable. I can't see why it wouldn't be. It needs: 1) Someone who is able to operate at every level from being on the streets to talking to commissioners and directors on the Board; 2) It requires an element of buy-in from clients, through achieving their trust; 3) You need key people in senior posts to drive it forward."*

Each MEAM pilot was based on four core elements taken from previous multiple needs programmes. These are: coordination, flexibility, consistency and measurement. Below we present an overview of each element and some tips for areas setting up a coordinated service. This information is taken from qualitative interviews carried out by Babcock and from presentations and discussions led by the pilots at regional events in early 2012.

Consistency in client recruitment

The NDT Assessment was used to identify clients. By focussing on behaviours and the level of engagement with services, the assessment helped each pilot to choose a caseload of similar clients. We have three tips to help local areas achieve consistency across their caseload:

(1) **Focus on the most excluded clients:** The MEAM pilot areas used the NDT Assessment© to identify clients who had behaviours consistent with multiple needs and exclusions and who had ineffective contact with services. MEAM wanted local areas to focus on the 15 most excluded clients they could identify, not just people that were "a bit difficult to work with".

Agency: *"Yes the clients were excluded and had chaotic lives. They [the pilots] have not shied away from difficult cases."*

Lead/Co-ordinator: *"It [The NDT Assessment] is simple and concise and it doesn't go on forever."*

(2) **Take an area-wide approach to client recruitment:** The pilots differed in the way that they recruited clients. The most successful approach was in Cambridgeshire, where they provided the NDT Assessment to all local agencies and invited workers to refer clients on the basis of this assessment. Sixty clients were referred and their NDT scores were cross-checked by the coordinator and the referring worker for consistency. The Cambridgeshire Operational Group then selected 15 clients for the coordinator's caseload.

(3) **Do not discharge clients prematurely:** The pilots differed in their approach to caseload management. Cambridgeshire and Somerset kept a relatively fixed caseload for the twelve months of the pilot, only discharging people in occasional circumstances. Cambridgeshire worked with 20 people (15 included in our evaluation) and Somerset worked with 18 (11 included in our evaluation). Derby had a different approach, discharging people after shorter periods of time if the Operational Group felt they were improving their connection to local services and no longer needed the help of the coordinator. Over the year, the Derby pilot worked with 31 people (13 included in our evaluation). MEAM feel that the more stable caseload model offers increased consistency for clients. It also simplifies data collection if an evaluation is to be performed.

Coordination

Each pilot employed one full time or two part time coordination workers, who engaged with individual clients in order to build trust and help clients navigate local services. In the experience of the pilot areas, one full time coordinator can manage a caseload of approximately 15 individuals. We have four tips to help areas coordinate existing services:

(1) **Allow the coordinator to develop a personalised service that supports clients and local agencies:** In all three areas, the role of the coordinator was very 'hands-on' - working closely with clients to build their trust; and working closely with local agencies to help them re-engage with clients.

Lead/Co-ordinator: "*We do face to face meetings; liaison, getting agencies to flex; helping people to paint their flats; getting community care grants; food parcels; chasing for these grants; representing people in court; pre-sentence reports; taking them where they need to be"*

Client: "*Sitting down and listening to the person and prioritising things that need to be done to improve the person's future.*"

Agency: "We're *very aware of the Co-ordinators. I've been freed up by the contact with the Co-ordinator – great to be able to phone about engaging a user and have two-way traffic.*"

(2) **Allow coordinators to follow clients across transitions and be free from organisational 'remits':** Coordinators need to be free from organisational targets, processes, procedures, and time constraints and to have the ability to follow clients across transitions. All the pilots made an effort to ensure that coordinators were seen as working 'for the area' and not for any existing agency, which helped coordinators build trust when clients had poor relationships with local services:

Agency: "*For the client, they [co-ordinators] provide befriending and are seen not just as another professional, but they also build up a good rapport and trust….It is good that one person can deliver information to the client from different agencies – it streamlines the process, and makes it easier for the client to take things on board and accept information on trust... The Co-ordinator has more time for the client than each representative of partner agencies could have.*"

Lead/Co-ordinator: "*It makes a huge difference to clients because they are dealing with one Co-ordinator with whom they have established a strong trust…Continuity is so important.*"

(3) **Build in time, resources and the right personnel for strategic support:** Pilot leads often supported coordinators with the strategic parts of their work, for example encouraging attendance at the Operational Group or Board and advocating for specific client interventions. This input was not funded by the pilots, but was vital for their success. Getting the right team in place is important as it was rare to find one person who could lead both the frontline and the strategic work.

(4) **Be clear that the focus is on a cheap investment in coordination, not a big new service:** The pilots set out to test the premise that a small investment in the coordination of *existing* local services could achieve outcomes for a small group of excluded individuals. The focus has been on better coordinating services already in place, rather than making the case for new and expensive multiple needs services.

Flexibility

Relevant statutory and voluntary partners sat on Boards and Operational Groups set up in each pilot area. These structures have helped pilot areas to build an area-wide responsibility for this group of individuals.

Boards met approximately every three months. They ensured senior-level, strategic commitment and given permission to do things differently. Operational Groups met approximately monthly. They provided a forum for case management, with those around the table committed to acting flexibly to find a new way forward for excluded clients. We have several tips to help areas provide flexible services:

Boards

(1) **Ensure broad membership and use key champions:** A broad membership of people at the right level is vital. All pilot areas reported difficulties in getting a 'full complement' of agencies for their Boards and in two areas it took significant time and effort to get the Board in place. However, once operational, all Boards had a mix of statutory and voluntary sector attendees comprising: housing, police, probation, voluntary sector, commissioners, mental health, voluntary and statutory housing, local drug and alcohol services, and health services.[17] Boards tended to be formed of senior-level directors or service managers. Some pilots stated that once they had identified a key senior-level champion the process of ensuring membership and attendance became much easier.

(2) **Be clear about the role of the Board:** It is important to be clear about the role of the Board and to agree this in the terms of reference. All pilots invested significant time in the Boards and this should be accounted for and funded. Some pilots found that sending agendas and minutes directly from the senior-level Chair improved attendance.

(3) **Build on existing structures:** It was helpful to build Boards on existing structures. This minimised the number of meetings that people needed to attend and ensured there was no duplication.

[17] Boards and Operational Groups sought members from the following agencies, though there were gaps in some pilot areas' structures: Voluntary sector agencies (across homelessness, criminal justice, drug treatment, mental health); Council housing department; Social services; Drug and Alcohol Action Team; Primary Care Trust; Mental Health Trust; Prisons; Probation; Police. See Appendix 2 for details of the Board and Operational Group in each area.

(4) **Take advantage of new contacts that the Board provides:** A number of the pilots mentioned the importance of informal contact with Board members between meetings. Giving the coordinator (or the pilot lead) the ability to pick up the phone and speak to someone on the Board directly about a particular client led to some excellent examples of service flexibility.

Lead/Co-ordinator: "*At the Board the agencies are working together….people have been able to make things happen.*"

Operational Groups

(1) **Ensure broad membership:** Good membership was vital for Operational Groups as well as Boards. The range of agencies was similar to Boards, but those attending were more likely to be frontline managers or workers.

(2) **Be clear about the role of the Operational Group and take advantage of new contacts:** The role of the Operational Group was easier for people to understand than that of the Board, with many individuals used to the idea of case management and conferencing. Clear terms of reference were still important. Many pilots felt that it was the Operational Group that delivered most of the flexibility in service provision. As with the Board, participants valued the new contacts made.

Lead/Co-ordinator: "*It has created relationships with other agencies. Now we have a direct line. It is good spending time with them and seeing how they work.*"

Agency: "*Relationship building has been brilliant and agencies/people have become a bit more flexible. Meeting people rather than just having a name [within other agencies] is useful.*"

(3) **Develop an area-wide responsibility for this group:** It was important to ensure a shared responsibility for clients across the Operational Group (and Board) and that everyone agreed to play their part.

Lead/Co-ordinator: "*Some agencies will flex and others won't. Some individuals will and some won't. I still think people aren't totally happy multi-agency working. Those that do, work well... [The pilot] has had an impact but it takes time. The Operational Group is working as it should.*"

Measurement

The similarity of the pilots has enabled us to evaluate their effect on client wellbeing and service use. We have four tips for local areas wishing to collect similar data:

(1) **Be clear about what you want to measure:** MEAM expected the pilots to result in increased client wellbeing and an overall decrease in service use costs. We therefore asked the pilots to collect data on service use (direct from local agencies) and information on wellbeing (from clients). MEAM also commissioned a qualitative research agency to undertake a series of interviews.

(2) **Don't try to collect too much service use data:** The data that we eventually collected on service use was less than originally intended. Some information was not available and some was not relevant. Local agencies were keen to provide data but in the case of nationally organised agencies it was sometimes more difficult to identify the relevant person to ask. Appendix 6 shows the final service use questionnaire.

(3) **Be aware of difficulties in collecting wellbeing data:** We asked the pilots to collect a range of information on wellbeing from clients, but quickly realised that this was too much data to comfortably collect. In the end, we focused on the NDT Assessment, Outcomes Star and WEMWBS. Even with this level of data collection, there were some delays as coordinators found that requesting data from clients early in the process could make it more difficult to build trust with that client.

(4) **Be aware of issues around data sharing:** The pilots collected data from local services then provided that data to us in an anonymised format. Consent was required from clients for the pilots to collect this data. Appendix 4 shows an example of a consent form used. Law firm Edwards Wildman Palmer UK LLP kindly provided us with pro bono advice to ensure that this consent form was adequate for the purposes of this particular study. In some cases, information sharing agreements between service providers facilitated the collection of data by the pilots. We understand that these agreements are not legally required when the client has given their consent. Notwithstanding this, some local agencies were not comfortable providing the relevant data to the service coordinators and instead provided it directly to the evaluation team in anonymised format.

Concluding remarks

Our findings

We have shown that the pilots resulted in a measureable and statistically significant improvement in client wellbeing. The service coordinators helped clients to access health, drug and alcohol, and housing services to which they did not previously have satisfactory access or with which they did not previously engage.

As clients have gained access to services, some costs have inevitably increased. MEAM had hoped that these costs would be offset by savings from a reduction in inappropriate service use such as arrests. This was the case in Cambridgeshire, where savings in crime costs more than outweighed the increases in the health, drug and alcohol, and housing costs incurred to help clients address their multiple needs.

While this is true for Cambridgeshire, this did not happen in the other two pilot areas. In Somerset, crime costs fell, but not by enough to outweigh the increased costs of providing other services. In Derby, crime costs themselves increased, driven particularly by four clients whose offending increased significantly as they entered the pilot.

Many individuals in the client group have experienced severe problems over many years and it can take a long time to help these clients to change their service use. It is possible that the clients in the Derby and Somerset pilot areas need a longer period of engagement to result in an overall reduction in costs.

We have followed the clients for a period of at most one year after enrolling in the pilot and an average of nine months. Some of these individuals are still at the beginning of a journey to address their needs. These individuals' service use remains high but may fall in the future with further help.

Recommendations for those working with adults facing multiple needs

In this report, we have made a number of recommendations for areas working with adults experiencing multiple needs and exclusions. These recommendations are based upon what we have learned from the MEAM pilots, suggestions from those involved in running them and suggestions from partner agencies.

We consider that the 'coordinator' approach to helping those experiencing multiple needs is an effective one that can provide clients with the means to access services they need. In addition, this approach provides a continuity of care as clients' lifestyles change. A service coordinator requires the support and cooperation of local agencies. We consider that two separate groups, one focussed on strategic issues and the other on operational issues can greatly facilitate this. It may be possible to base these groups upon pre-existing structures.

The wellbeing and service use data collected as part of this study is some of the strongest available on multiple needs and exclusions. This report will be of interest to local and national policymakers and is relevant to the development of coordinated services in more local areas.

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Appendix 2: The organisations behind each pilot

Cambridgeshire

The coordinator in the Cambridgeshire pilot area was Tom Tallon. Prior to becoming the coordinator for the Cambridgeshire pilot area, Tom worked in the voluntary sector within Tenancy Support Services in a multi-disciplinary team working with former homeless people and those at risk of homelessness.

The project leads in the Cambridgeshire pilot area who were closely involved with the strategic elements of the work were:

- Diane Docherty, Homelessness Service Development Manager at Cambridge City Council; and
- Fay Haffenden, a Consultant in Public Health at NHS Cambridgeshire.

The Cambridgeshire pilot was funded by MEAM, Cambridgeshire County Council, Cambridgeshire City Council, Cambridgeshire NHS and Cambridge Constabulary. Jimmy's Nightshelter provided additional resource support in the form of 16 support hours per week from their staff team.

If you would like to know more about the Cambridgeshire pilot and ongoing work with adults facing multiple needs and exclusions in the Cambridgeshire area, please contact:

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In Cambridgeshire, the MEAM Board was superimposed upon the Homeless Joint Strategic Needs Analysis (JSNA) Steering Group and the County Homelessness Executive.

The table below shows the individuals and the organisations they represent who were part of the Cambridgeshire Board and Operational Group.

Agency	Cambridgeshire Board	Cambridgeshire Operational Group
Voluntary sector agencies – Homelessness	▪ Brian Holman, Cambridge Cyrenians ▪ Christine Spooner, Homelesslink	▪ Cathy Hembry, Director, Wintercomfort for the Homeless ▪ Brian Holman, Cambridge Cyrenians ▪ Henry Brown, General Manager, Jimmy's Night Shelter ▪ David Smyth, Regional Performance Manager / Sam Pett, Riverside English Churches Housing Group ▪ Rachel Everitt, Team Manager / Vicki Markiewicz, Deputy Director, Crime Reduction Initiative Street Outreach Team

Agency	Cambridgeshire Board	Cambridgeshire Operational Group
Voluntary sector agencies – criminal justice	N/A	N/A
Voluntary sector agencies – drug and alcohol treatment	N/A	N/A
Voluntary sector agencies – mental health	N/A	N/A
Housing department	▪ Jane Hollingworth, Head of Housing, East Cambridgeshire District Council ▪ Sarah Gove, Housing & Neighbourhood Services Manager, Fenland District Council ▪ Jon Collen, Housing Needs & Resources Manager, Huntingdonshire District Council ▪ Sue Carter/Heather Wood, Housing Advice and Options Manager (job share), South Cambridgeshire District Council ▪ David Greening, Housing Options and Homeless Manager, Cambridge City Council	N/A
Social services	▪ Ivan Molyneux, Adult Safeguarding and Quality Manager, Cambridgeshire County Council	N/A
Drug and Alcohol Action Team	▪ Jessica Bendon, Drug and Alcohol Action Team Treatment Coordinator, Cambridgeshire County Council ▪ Vicky Crompton, DAAT Co-ordinator ▪ Chris Taylor ▪ JC Anstee	▪ Vicky Crompton, DAAT Co-ordinator
Primary Care Trust	▪ Fay Haffenden, Consultant in Public Health, NHS Cambridgeshire ▪ Lee McManus, Commissioning Service Improvement Manager – Older People	▪ Fay Haffenden, Consultant in Public Health ▪ John Ellis, Mental Health Commissioning Lead ▪ Claire Warner, Commissioning Service Improvement Manager for Mental Health ▪ Jessica Stokes/Jodie Crane, Screening, Children and Health Inequalities Manager
Mental Health Trust	N/A	▪ Fiona Blake, Consultant Psychiatrist ▪ Maggie Lawrence ▪ Christine Robertson, Team Manager North East Intake and Treatment Team ▪ Neil Winstone
Prisons/Integrated Offender Management	▪ Mark Alexander, Detective Inspector, Cambridgeshire Constabulary	N/A
Probation	▪ Alison Hancock, HR Director, Cambridgeshire and Peterborough Probation Trust	N/A

Agency	Cambridgeshire Board	Cambridgeshire Operational Group
Police	▪ Dick Moore, Head of Operations and Neighbourhood Support, Cambridgeshire Constabulary	▪ Dick Moore, Head of Operations and Neighbourhood Support, Cambridgeshire Constabulary
Supporting People	▪ Joe Keegan, Supporting People Acting Lead Officer, Cambridgeshire County Council	▪ Ian Crowther, Supporting People Contracts Officer, Supporting People, Cambridgeshire County Council
Cambridgeshire County Council	▪ Mike Hay Head of Quality and Transformation Strategy and Commissioning ▪ Robert Nicholls Interim Mental Health Commissioning Officer	▪ Trevor Baker, Research Manager ▪ Ivan Molyneux, Adult Safeguarding and Quality Manager
Cambridge City Council	▪ Liz Bisset (Chair), Director of Customer and Community ▪ Alan Carter, Head of Strategic Housing Services	▪ Diane Docherty, Single Homeless and Rough Sleepers Co-ordinator
Primary Care	N/A	▪ Liz Belham, GP, Cambridge Access Surgery, Cambridgeshire Community Services NHS Trust ▪ Jon Lamb, Practice Manager, Cambridge Access Surgery, Cambridgeshire Community Services NHS Trust
Secondary Care	N/A	▪ Adrian Boyle, A&E Consultant, Cambridge University Hospitals NHS Foundation Trust
Drug and alcohol services provider	N/A	▪ Susie Talbot DAAT Co-ordinator (Drug and Alcohol Action Team Co-ordinator)
Communities and Local Government	▪ Tracey Brushett	N/A

Derby

The coordinator in the Derby pilot area was Julie Morgan. Prior to becoming the coordinator for the Derby pilot area, Julie had worked in a children's home, emergency accommodation for homeless people, and as a special needs/basic skills teacher. She is a trained counsellor, with qualifications in Cognitive Behavioural Therapy.

The project leads in the Derby pilot area who were closely involved with the strategic elements of the work were:

- Jackie Carpenter, Strategic Development Manager at Derventio Housing Trust; and
- Glynis Hawkes, Young Person's Housing Officer in Derby City Council's Adults, Health & Housing team.

The Derby pilot was funded by MEAM, with match funding from:

- Riverside ECHG, through the already established street drinkers case manager, who worked closely with the Complex Needs Case-Manager; and
- Derventio Housing Trust and Derby City Council in the form of staff time and additional contributions to office costs. Derventio contributed the time of the coordinator's line manager. Both Derventio and Derby City Council contributed staff time to lead the Board and Operational Group, and to promote and champion MEAM within the city.

If you would like to know more about the Derby pilot and ongoing work with adults facing multiple needs and exclusions in the Derby area, please contact:

Jackie Carpenter, Strategic Development Manager, Derventio Housing Trust
33 Boyer Street
Derby
DE22 3TB
01332 642167
jackie.carpenter@derventiohousing.com

The table below shows the individuals and the organisations they represent who were part of the Derby Board and Operational Group.

Agency	Derby Board	Derby Operational Group
Voluntary sector agencies – Homelessness	▪ Sarah Hernandez, Managing Director, Derventio Housing Trust ▪ Andrew Locke, Head of Housing & Support, Derventio Housing Trust ▪ Jackie Carpenter, Strategic Development Manager, Derventio Housing Trust	▪ Jackie Carpenter, Strategic Development Manager, Derventio Housing Trust ▪ Carly Betts, Milestone House Manager, Derventio Housing Trust ▪ Jan Harrison and Reg Smith, Area Managers, Riverside ECHG ▪ Jo Burton, Centenary House Manager, Riverside ECHG ▪ Ken Gibbons and Emma Mason, Hartington House Managers, Metropolitan Support Trust ▪ Chris Steadman, Hartington House Senior, Metropolitan Support Trust ▪ Angela Blaney, Support Worker, Hartington House, Metropolitan Support Trust ▪ Helen Repton and Pat Zadora, Hostel & Day Centre Managers, Padley Group ▪ Sue Kidney, Support Worker, Padley Day Centre ▪ Sue Griffin, Supported Housing Manager, YMCA Derbyshire
Voluntary sector agencies – criminal justice	N/A	▪ Dale Nicholson, Manager of Derby service, Nacro ▪ Paul Cooper and Jason Hanshaw, Referrals Officer, NACRO
Voluntary sector agencies – drug and alcohol treatment	N/A	▪ Karen Laverick, Service Manager Derby Tier 2 and Tier 3 Services, Phoenix Futures ▪ John Green, Team Manager, Tier 2 & Tier 3 Services, Phoenix Futures ▪ Mark Evans, Alcohol Case Manager, Riverside ECHG ▪ Monica McAlindon and Helen Hinchcliffe, Manager, ADS
Voluntary sector agencies – mental health	N/A	▪ Marjorie McDonald, Manager of Derby service, Rethink ▪ Renée Bowler and Jacqui Smith, Rethink (working in HMP Nottingham)

Agency	Derby Board	Derby Operational Group
Housing department	▪ Glynis Hawkes, Derby City Council, Young Person's Housing Officer, Adults, Health & Housing Brian Frisby, Derby City Council, Director for Younger Adults & Housing, ▪ Lisa Callow, Derby City Council Head of Homelessness Services & Housing Advice	▪ Glynis Hawkes, Derby City Council, Young Person's Housing Officer, Adults, Health & Housing ▪ Matt Palmer, Single Point of Entry Manager, Derby City Council Adults, Health & Housing
Social services	▪ Pat Gallimore, Head of service, access and direct services, Adults, Health & Housing ▪ Carol Fox, Head of service, assessment and enablement, Adults, Health & Housing	▪ Jane Witherow, Screening and Assessment Manager, Derby City Council Adults, Health & Housing
Drug and Alcohol Action Team	▪ Dr Richard Martin, Head of service, substance misuse, PCT ▪ Laura Follows, Senior Research & Information Officer, Derby City & Neighbourhood Partnerships (rep Dr Richard Martin)	N/A
Primary Care Trust	▪ Dr Richard Martin, Head of service, substance misuse, PCT ▪ Richard Mullings, PCT, (rep Derek Ward, Interim Director of Public Health)	▪ Kath Butler, Community Practice Nurse, Community Health Team for Homeless People
Mental Health Trust	▪ Griff Jones, Mental health lead, Derby City Council	▪ Kath Butler, Community Practice Nurse, Community Health Team for Homeless People ▪ Ben Ross, Outreach Worker/Social Worker, Notts Healthcare
Prisons/Integrated Offender Management	▪ Darren Poole and Neil Muldoon, Regional remit, Prison service	▪ Mary Bacon, Probation Officer, seconded to Derby City Council Single Point of Entry team
Probation	▪ Mark Self, Partnerships Officer, Senior Probation Officer	▪ Mary Bacon, Probation Officer, seconded to Derby City Council Single Point of Entry team
Police	▪ Inspector Andy King, Persons Susceptible to Harm lead ▪ Inspector Jock Munro, Head of Performance Delivery	▪ PC David Keane, Community Safety, Performance Delivery ▪ PCSO Jenny Sadler
Other	▪ Mohammed Sabeel, Homeless Link, Regional Advisor ▪ Steve Bryan, Safeguarding lead officer, Derby City Council (received minutes but did not attend meetings) ▪ Frank Preston and Steve Fleming, peer reviewers and client representatives	▪ Jo Woodland, Drug Interventions Programme Co-ordinator, Community Safety Partnership ▪ Jo Seekings, Integrated Offender Management, Community Safety Partnership ▪ Davina Patel, Criminal Justice Development Officer, Women's Work (received minutes but did not attend meetings)

Somerset

The Somerset pilot appointed two coordinator posts:

- Gale Rowan has a background in counselling, with experience in a variety of related roles including setting up, managing and coordinating volunteers for a telephone bereavement helpline. Before the Somerset MEAM pilot, Gael was the Family Support Worker for ReRun, Dorset Runaways Service.

- Crissy Creasey is a qualified counsellor. She has worked on several new projects including Conflict To Enterprise at Yeovil Foyer, Avon & Somerset Prolific Offenders Unit and ReRun, Dorset Runaways Service. She has volunteered for Yeovil Night Shelter and Probation and has a strong interest in substance misuse and homelessness issues.

The project leads in the Somerset pilot area who were closely involved with the strategic elements of the work were:

- Sarah Ward, Homelessness and Substance Misuse Manager at Bournemouth Churches Housing Association;
- Hester Rees, Senior Housing Options & Development Officer at Mendip District Council;
- Kirsty Coles, Accommodation Officer (first half of the year); and
- Judie Jones, Accommodation Officer (second half of the year).

The Somerset pilot was funded by MEAM, Mendip and Sedgemoor District Councils, and Bournemouth Churches Housing Association.

If you would like to know more about the Somerset pilot and ongoing work with adults facing multiple needs and exclusions in the Somerset area, please contact:

Sarah Ward, Homelessness and Substance Misuse Manager, BCHA
01202 410500
07966 808 849
sarahward@bcha.org.uk

The Somerset pilot made use of two separate Operational Groups, organised by geographical location.

The table below shows all the individuals and the organisations they represent who were part of the Somerset Board and Operational Groups.

Agency	Somerset Board	Somerset Operational Groups
Voluntary sector agencies – homelessness	▪ John Shipley, Taunton Association for the Homeless ▪ Stephen Fowler, Manager, Connect Centre ▪ Sharon Dyke, Area Manager, Novas	▪ John Shipley, Managing Director, Taunton Association for the homeless ▪ Major Neil Davies, Salvation Army ▪ Sally Brace, Senior Support Worker, Novas Scarman ▪ Ian Hall, Volunteer, British Red Cross ▪ Jo Harvey, Support Worker, Novas ▪ Stef Turner, Resettlement Support, Mendip YMCA ▪ Rev Stephen Fowler, Leadership team, Elim Connect Centre ▪ David Pepper, Tara Rufus and Wendy Upton, Somerset Families Floating Support Service ▪ Jonathan Kerslake, Senior Housing Advisor, Shelter ▪ Gary Kingman, Grace Harris House Supported Housing, Shepton Mallet ▪ Alison Slimm and Suzanne Meylan, Magdalene House, Glastonbury, Supported Housing
Voluntary sector agencies – Criminal justice	N/A	N/A
Voluntary sector agencies – drug and alcohol treatment	▪ Darren Woodward, Area Manager, Turning Point	▪ John Saunders, Project Worker, Turning Point ▪ Penny Walster, DHI Bath ▪ Tim Roberts, Turning Point
Voluntary sector agencies – mental health	▪ Di Monaghan, Mind Sedgemoor	▪ Diana Monaghan, Mind Sedgemoor ▪ Kieran Taafe, Rethink
Housing department	▪ Jerry Milton, Housing Advice Manager ▪ Kirsty Coles, Accommodation Officer ▪ Jai Vicks, Housing Options Team Manager ▪ Hester Rees, Senior Housing Options & Development Officer, Mendip District Council;	▪ Kirsty Coles ▪ Keith Pippard, Housing, Mendip District Council ▪ Jane Winsley, Housing Administrative Officer, Mendip District Council ▪ Judith Norman, Housing Options Assessment, Mendip District Council
Social services	▪ Miriam Madison, Corporate Director, Adult Social Care ▪ Trevor Gillham, Senior Manager	▪ Sue Park, Emergency Duty Team ▪ Sandra Bishop, Team Leader, Leaving Care
Drug and Alcohol Action Team	▪ Amanda Payne, Drug and Alcohol Action Team commissioning manager	▪ Amanda Payne, Drug and Alcohol Action Team Coordinator
Primary Care Trust	▪ Penny Guppy, Manager NHS Commissioning, PCT	▪ Penny Guppy, Manager NHS Commissioning, PCT ▪ Caroline Gamlin, Director of Public Health, PCT
Mental Health Trust	▪ Douglas Plume, Assertive Outreach, Community mental Health Team	▪ Douglas Plume, Assertive Outreach, Community mental Health Team
Probation	▪ David King, Somerset probation	▪ Paula Sanchez, Service Officer, Probation ▪ Mark Tuke, Probation ▪ Carol Price, Area Accommodation Officer, Probation

Agency	Somerset Board	Somerset Operational Groups
Police	▪ Inspector Roger Tolley, Somerset and Avon Police ▪ Chief Inspector Peter Saban, Somerset and Avon Police	▪ Peter Williams, Avon & Somerset Police ▪ PC Ria Reece, Avon & Somerset Constabulary ▪ PC Ed Woolmington, Avon & Somerset Constabulary
Other	▪ Dick Brummit and Abbi Taylor, Street Pastors ▪ Allison Griffin, Corporate Director, Customers and Communities, Sedgemoor District Council ▪ Tracy Aaron, Corporate Manager, Built Environment, Mendip District Council ▪ Brian Swann, Director of Operations and Partnerships, Bournemouth Churches Housing Association	▪ Jimmy Hood, Manager, Citizens Advice Bureau ▪ Kristy Blacwell, Community Safety Officer, Sedgemoor District Council ▪ Rhod Salter, Deputy Manager, Frome Citizens Advice Bureau ▪ Don Hart, Wells Vineyard Church ▪ Jo-Anne Bevan and Terry Pitfield, Florish Homes, Registered Social Landlord ▪ Sandy Dee Shapland, Sanctuary Housing, Registered Social Landlord ▪ Gemma Wilkes, Knightsbridge Housing, Registered Social Landlord ▪ Suzanne Harris, Community Safety Coordinator ▪ Roz Wilkins, Area Regeneration Manager Glastonbury, Mendip District Council ▪ Rhiannon Jennings, Big Issue

Appendix 3: The NDT Assessment

The service coordinator should select one statement that best applies to the person being assessed. All scores should be based on the past one month.

1. Engagement with frontline services

Score	Description
0	Rarely misses appointments or routine activities; always complies with reasonable requests; actively engaged in tenancy/treatment.
1	Usually keeps appointments and routine activities; usually complies with reasonable requests; involved in tenancy/treatment.
2	Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment.
3	Non-compliant with routine activities or reasonable requests; does not follow daily routine, though may keep some appointments.
4	Does not engage at all or keep appointment.

2. Intentional self harm

Score	Description
0	No concerns about risk of deliberate self-harm or suicide attempt.
1	Minor concerns about risk of deliberate self-harm or suicide attempt.
2	Definite indicators of risk of deliberate self-harm or suicide attempt.
3	High risk to physical safety as a result of deliberate self-harm or suicide attempt.
4	Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt.

3. Unintentional self harm

Score	Description
0	No concerns about unintentional risk to physical safety.
1	Minor concerns about unintentional risk to physical safety.
2	Definite indicators of unintentional risk to physical safety.
3	High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment.
4	Immediate risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment.

4. Risk to others

Score	Description
0	No concerns about risk to physical safety or property of others.
2	Minor antisocial behaviour.
4	Risk to property and/or minor risk to physical safety of others.
6	High risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour.
8	Immediate risk to physical safety of others as a result of dangerous behaviour or offending/criminal behaviour.

5. Risk from others

Score	Description
0	No concerns about risk of abuse or exploitation from other individuals or society.
2	Minor concerns about risk of abuse or exploitation from other individuals or society.
4	Definite risk of abuse or exploitation from other individuals or society.
6	Probably occurrence of abuse or exploitation from other individuals or society.
8	Evidence of abuse or exploitation from other individuals or society.

6. Stress and anxiety

Score	Description
0	Normal response to stressors.
1	Somewhat reactive to stress, has some coping skills, responsive to limited intervention.
2	Moderately reactive to stress; needs support in order to cope.
3	Obvious reactiveness; very limited problem solving in response to stress; becomes hostile and aggressive to others.
4	Severe reactiveness to stressors, self-destructive, antisocial, or have other outward manifestations.

7. Social effectiveness

Score	Description
0	Social skills are within the normal range.
1	Is generally able to carry out social interactions with minor deficits, can generally engage in give-and-take conversation with only minor disruption.
2	Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate.
3	Uses only minimal social skills, cannot engage in give-and-take of instrumental or social conversations; limited response to social cues; inappropriate.
4	Lacking in almost any social skills; inappropriate response to social cues; aggressive.

8. Alcohol and drug abuse[18]

Score	Description
0	Abstinence; no use of alcohol or drugs during rating period.
1	Occasional use of alcohol or abuse of drugs without impairment.
2	Some use of alcohol or abuse of drugs with some effect on functioning; sometimes inappropriate to others.
3	Recurrent use of alcohol or abuse of drugs which causes significant effect on functioning; aggressive behaviour to others.
4	Drug/alcohol dependence; daily abuse of alcohol or drugs which causes severe impairment of functioning; inability to function in community secondary to alcohol/drug abuse; aggressive behaviour to others; criminal activity to support alcohol or drug use.

9. Impulse control

Score	Description
0	No noteworthy incidents.
1	Maybe one or two lapses of impulse control; minor temper outbursts/aggressive actions, such as attention-seeking behaviour which is not threatening or dangerous.
2	Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening.
3	Impulsive acts which are fairly often and/or of moderate severity.
4	Frequent and/or severe outbursts/aggressive behaviour, e.g., behaviours which could lead to criminal charges / Anti Social Behaviour Orders / risk to or from others / property.

10. Housing

Score	Description
0	Settled accommodation; very low housing support needs.
1	Settled accommodation; low to medium housing support needs.
2	Living in short-term / temporary accommodation; medium to high housing support needs.
3	Immediate risk of loss of accommodation; living in short-term / temporary accommodation; high housing support needs.
4	Rough sleeping / "sofa surfing".

[18] Drugs include illegal street drugs as well as abuse of over-the-counter and prescribed medications.

Appendix 4: Example client consent form

[Pilot area] MEAM Service Evaluation Consent Form

Introduction

- The [Pilot area] MEAM service is one of three pilots across the country being supported by a national coalition of charities called Making Every Adult Matter.
- The [Pilot area] MEAM service is seeking to better coordinate existing local services, improve outcomes for clients, and show that the new approach is beneficial to individuals, local agencies and the local area.
- To assess this, an evaluation of anonymous data is being carried out by a company called FTI Consulting.

About the evaluation

- To complete the evaluation FTI Consulting will need anonymous data about the individuals involved in the MEAM service. Some of this information will come from the clients and some will be collected directly from local agencies.
- [Local agency] will act as the data controller for the purposes of the collection and processing of personal data in accordance with this consent form. They will collect information from relevant agencies, make it anonymous and pass it to FTI Consulting.
- The data collected is likely to be considered sensitive personal data under the Data Protection Act 1998 ("DPA"). Anyone handling this data before it has been made anonymous must therefore comply with the first data protection principle of the Data Protection Act. This means that data must be (a) processed fairly and lawfully and (b) processed in accordance with a relevant condition set out in Schedule 3 of the DPA.
- To meet these requirements (a) the client must be given specific information on how the data will be processed and (b) the client must give their explicit consent.

About this form

- The completion of this form ensures that both requirements are met by [local agency] and by any agents acting on their behalf.
- Section A provides specific information to the client about the evaluation and how the data will be processed. Section B allows the client to give their explicit consent.

Section A: Specific information for the client

The following information should be provided to each client:

- You are currently, or have in the last 12 months, received a service from the [Pilot area] MEAM pilot. This service is seeking to better coordinate existing local services, improve outcomes for clients, and show that the new approach is beneficial to individuals, local agencies and the local area.

- To assess this, an evaluation is being carried out by a company called FTI Consulting.

- To complete the evaluation FTI Consulting will need anonymous data about the individuals involved in the [Pilot area] MEAM service. Some of this information will come directly from you and some will be collected directly from local agencies by [local agency].

- Once this data has been received by [local agency], it will be made anonymous. It will then be passed to FTI Consulting who will analyse it and use it to produce a report about the pilot, which will be published. You are welcome to see a copy of the report when it is available. Once the report has been published all data collected by [local agency] will be destroyed.

- To comply with the law we need to provide you with this information and seek your explicit consent to be involved. If you are happy to be part of the evaluation please now complete section B. Thank you.

Section B: Client consent

MEAM area	[Pilot area]
Client name	
Client ID (eg [Pilot area]1)	

Please read the following and initial each box if you agree with the statement:

1	I confirm that I understand the information provided in Section A above. I have had the opportunity to consider the information, ask questions, and have had these questions answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and this will not affect my legal rights, or my use of this or any other service.	
3	I understand that my participation will require me to complete a personal details form, Outcomes Star, and Warwick-Edinburgh Mental Well-being Scale on a quarterly basis. I understand that I will be supported in doing this by my key worker from the MEAM project.	
4	I understand that my participation will also require information about me to be collected from local agencies by [local agency]. I give my explicit consent for this information to be accessed by the relevant agency and passed to [local agency]. I have confirmed this by signing next to each category of data in Annex A. I understand that the data collected will cover the time I was on the MEAM project and the twelve months beforehand.	
5	I understand that the information collected will be stored securely by [local agency]. It will not be available to anyone else in a form that identifies me. Only anonymous data will be passed to FTI Consulting. Once the evaluation report is published the data collected by [local agency] will be destroyed.	
6	FTI Consulting will produce a report with the anonymous data that is passed to them. I understand that I will be able to see a copy of the report when it is published.	
7	I understand that I may be contacted by the team at FTI Consulting at a later date to participate in a focus group or face to face interview to discuss my experience of this service. I do not have to take part in this aspect if I do not want to.	
8	I agree to take part in this evaluation	

Name:
Signed:
Date:

Witnessed by

Name:
Signed:
Date:

Annex A

Information to be collected for MEAM pilot evaluation

I give my explicit consent for the following information to be accessed by the relevant agency and passed to [local agency]:

Offending (from the Police and my Police National Computer record)

- Number of cautions
- Number of arrests
- Number of other contacts with the police (e.g. when police are called to an incident, or you are a victim)
- Number of times you have appeared in a Magistrates or Crown Court
- Time in police custody
- Time in prison
- Probation orders you have been on

Health (from the PCT, hospital, your GP and Ambulance Trust)

- Number of GP appointments
- Number of outpatient appointments
- Number of visits to A&E
- Number of admissions to hospital and length of stay
- Number of times called 999 for ambulance

Mental Health (from the Mental Health Trust)

- Number of appointments with CPN or other intervention from CMHT
- Number of admissions to hospital and length of stay

Drug and Alcohol services (from the DAAT or providers)

- Number of assessments by drug/alcohol team
- Number of attendances at drug/alcohol community treatment services
- Information on substitute prescriptions (yes/no and how long)
- Number of nights in residential detox for drugs/alcohol

Housing (from hostels, accommodation providers and the local authority)

- Information on where you lived and for how long
- Number of evictions and abandonments

Adult Social Care (from the local authority)

- Number of CCA assessments
- Number of contacts with social workers
- Whether you have a care package in place

Appendix 5: Example initial questionnaire

Personal details questionnaire

Information about this questionnaire

Aim
To collect information about the background of the clients enrolled in the pilots.

When to complete
As soon after a client enters the programme as possible.

How to complete the questionnaire
This questionnaire has been designed to be completed by the key worker who should ask each of the questions to the client.

If a client declines to answer a particular question, please indicate this by placing "D" in the relevant box.

Key points to note
When completing questionnaires with the client, please note the following:
(1) Client interviews should be conducted in private.
(2) The first time a client completes a questionnaire, the interviewer should first ask the client to read the consent form, or explain the information to the client.
(3) The interviewer should then ask the client to initial and sign the consent form.

Submitting completed questionnaires
Please email completed forms to the evaluation team.

Please do not write the client's name on forms submitted to FTI Consulting or Compass Lexecon. Instead, please allocate each client a unique identifier such as "Cambridge 6". The same identifier should be used on all forms relating to the same client.

Using this spreadsheet
Please use a separate tab for each client.

Questions
If you have questions about data collection, please contact the evaluation team.
If you have any other questions about the MEAM pilots, please contact Oliver Hilbery.

Personal details questionnaire

Client identifier (e.g. Derby 1)

Date questionnaire completed (dd/mm/yyyy)

(1) What is your gender?

- ○ Male
- ○ Female

(2) What is your date of birth (dd/mm/yyyy)?

(3) What is your religion?

- ○ No religion
- ○ Christian, including all denominations
- ○ Muslim
- ○ Jewish
- ○ Hindu
- ○ Buddhist
- ○ Sikh
- ○ Other (please specify)

(4) How long have you lived in this town? years months

(5) What connections do you have to the local area? (tick all that apply)

- ☐ Lived in the area as a child or student
- ☐ Have family in the area
- ☐ Work in the area
- ☐ Previously worked in the area
- ☐ Have a partner in the area
- ☐ Have friends in the area
- ☐ None
- ☐ Other (please specify)

(7) What is your marital status?

- ☐ Single
- ☐ In a relationship
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow
- ☐ Client did not answer

(8) How many children under 18 do you have?

(9) How many children over 18 do you have?

(10) What is your ethnic group?

White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other white background, write in: _____

Mixed / Multiple

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed/multiple ethnic background, write in: _____

Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian/ Asian British background, write in: _____

Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean
- ☐ Black British
- ☐ Any other black background, write in: _____

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic background, write in: _____

(11) Do you identify as:

○ Lesbian/gay	○ Other
○ Heterosexual	○ Prefer not to state
○ Bisexual	

(12) For how many years have you been in contact with each of the following organisations?

Social services	
Drug treatment services	
Alcohol treatment services	
Homelessness services	
Mental health services	
Offender services	

(13a) As a child, did you spend any time in care?

○ Yes
○ No
○ Client did not answer

(13b) If yes, for approximately how many years was this?

(14a) Are you currently...? (yes/no)

homeless	
using mental health services	
using drug or alcohol services	
in prison	

(14b) If you are currently homeless, how many years ago was it that you were last not homeless?

(15a) Have you ever...?

been homeless	
used mental health services	
used drug or alcohol services	
been in prison	

(15b) If you answered yes to one of the above questions, how old were you when you first…?

became homeless	
used mental health services	
used drug or alcohol services	
went to prison	

(16) How is your health in general?

- ○ Very good
- ○ Good
- ○ Fair
- ○ Bad
- ○ Very bad
- ○ Client did not answer

(17) What is your current employment status?

- ○ Paid or self employment
- ○ Voluntary employment
- ○ Unemployment
- ○ Student
- ○ Retired
- ○ Unable to work
- ○ Other (please specify)
- ○ Client did not answer

(18) What is currently your main source of income?

- ○ Paid or self employment
- ○ Casual work/cash in hand work
- ○ Support from family or friends
- ○ Illegal income
- ○ State benefits
- ○ Pension
- ○ Begging
- ○ Other (please specify)
- ○ Not known
- ○ Client did not answer

(19) How many units of alcohol have you drunk on average each week in the last three months?
Please refer to the alcohol units converter

(20) Have you been a victim of crime in the last three months?

- ○ Yes
- ○ No
- ○ Not known
- ○ Client did not answer

(21) Do you have any other comments you would like to record?

Alcohol units converter

Quarterly questionnaire

	%ABV	Units
Beer, lager or cider		
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9
Wine		
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	9
Spirits and Alcopops		
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
Bottle of alcopops (275ml)	5	1.5

Appendix 6: Example service use questionnaire

The following example service use questionnaire shows the variables we used and the general format for collecting the data. Space was provided for agencies to complete 24 months of data, covering the year before the pilot and the year of the pilot. The relevant months were then used for the analysis. In the attached we show just three months to allow for larger text.

Service use questionnaire

Information about the service use questionnaire

Aim
To collect information about the service use of clients.

When to complete the service use return
Monthly service use data is required for every client who enters the service.
Service use returns should be completed in respect of each of the twelve months prior to enrolment and each of the twelve months after enrolment (including for any clients who leave or are discharged).

How to complete the service use return
The boards at each pilot area have committed to providing this information to MEAM. It should be collected by liaising with contacts at local service providers and by making use of local data sharing agreements. Please try to complete as many questions as possible.

Submitting completed returns
Please email completed forms to the evaluation team.

Please do not write the client's name on forms submitted to FTI Consulting or Compass Lexecon. Instead, please allocate each client a unique identifier such as "Cambridge 6". The same identifier should be used on all forms relating to the same client.

Using this spreadsheet
Please use a separate tab for each client.

Questions
If you have questions about data collection, please contact the evaluation team.
If you have any other questions about the MEAM pilots, please contact Oliver Hilbery.

Client ref:

CRIME DATA (POLICE)

How many times has the client had the following contact with the police/crime services?

	Jan-10	Feb-10	Mar-10	etc
Cautioned by police				
Arrested by police				
Other police contact for offences				
Other police contact as a victim				
For how many offences has the client attended a magistrates court?				
For how many offences has the client attended a crown court?				
How many nights has the client spent in police custody?				

For the court appearances above, please list the prison sentence given in days - put zero if there was no custodial sentence or found innocent				

If the client was in prison in Jan 10 please provide the sentence start date and length in days	

CRIME DATA (PROBATION)

How many times has the client had contact with probation services?

	Jan-10	Feb-10	Mar-10	etc
Contact with a probation officer				

HEALTH DATA (PCT and GP)

How many times has the client received the following medical assistance?

	Jan-10	Feb-10	Mar-10	etc
Visit to GP				
Visited A&E				
Outpatient appointment				

	Jan-10	Feb-10	Mar-10	etc
How many admissions to hospital has the client had (via any route)?				
How many nights in hospital did this result in?				

MENTAL HEALTH DATA (MHT)

How many times has the client received the following medical assistance?

	Jan-10	Feb-10	Mar-10	etc
General appointment with CMHT				
Intervention from CMHT (i.e. therapy session)				

	Jan-10	Feb-10	Mar-10	etc
How many admissions to a mental health hospital has the client had (via any route)?				
How many nights in hospital did this result in?				

	Y	N	Not known
Is the client subject to the Care Programme Approach			

DRUG AND ALCOHOL DATA (DAAT)

	Jan-10	Feb-10	Mar-10	etc
How many one-to-one contacts has the client had with a drug/alcohol treatment team?				
How many group session contacts has the client had with a drug/alcohol treatment team?				
For how many weeks has the client been receiving substitute prescriptions (e.g. methadone)? If the whole month put "4"				

How many nights has the client spent in rehab and detox?

	Jan-10	Feb-10	Mar-10	etc
For help with drug abuse?				
For help with alcohol abuse?				
For help with drug and alcohol abuse?				

HOUSING DATA (COUNCIL AND PROVIDERS)

Please indicate the number of nights that the client has spent in the following accommodation types.

	Jan-10	Feb-10	Mar-10	etc
Sleeping rough				
Temporary accommodation				
Night shelter				
Cold weather provision				
Direct access hostel				
Second stage supported accommodation				
Other temporary accommodation (specify)				
Permanent accommodation				
Own social tenancy				
Own PRS tenancy				
Room in shared PRS property				
Client's own house				
Other permanent accommodation (please specify)				

How many times has the client?

	Jan-10	Feb-10	Mar-10	etc
Lost a permanent tenancy (evicted or abandoned)				
Lost a temporary tenancy (evicted or abandoned)				

SOCIAL CARE (COUNCIL)

	Jan-10	Feb-10	Mar-10	etc
How many times has the client had a CCA assessment				
How many times has the client seen a social worker?				

	Y	N	Not known
Does the client have a care package in place?			
Was this care package put in place while the client was in the MEAM service			

Appendix 7: Unit costs

We have calculated the cost of providing services to the client group based upon publicly available unit cost data from a range of sources. In the tables below we set out the unit costs we use in our analysis.

Some of the unit costs we rely upon were published in 2011. Other costs were published in earlier years. Where this is the case, we have adjusted for inflation using the GDP deflator. For further discussion of this adjustment, please see the Technical Appendix.

Due to differences in service provision and wage rates, unit costs vary across the country. We assume national average values in the majority of cases.

Criminal justice system unit costs assumed

Service	Unit cost	Basis	Source
Arrest	£2,130	£1,930 plus inflation.	Think Family (2010), page 10.
Other police contact	£17	We use this category for police cautions, contact with the police as a victim of crime, contact with probation officers and any other police contact. We assume that other police contact comprises one hour of a police constable's time. The average police constable's salary is £31,032 (pay band 5). We assume that the average constable works for 40 hours a week, 47 weeks a year. One hour of a police constable's time therefore costs approximately £17.	Winsor (2011). Table 1.1.
Magistrates court attendance	£993	£760 plus inflation. This compares to £746 stated in Think Family (2010).	Home Office (1999), page 2.
Crown court attendance	£11,241	£8,600 plus inflation. This is an average cost for both guilty and not guilty pleas across all indictable offenses. This compares to £10,858 stated in Think Family (2010).	Home Office (1999), page 2.
Nights in prison	£74	We calculate this figure from an annual figure of £26,978, which is an average cost across a prison population of 84,753 individuals. This estimate includes direct resource expenditure only. It excludes overheads met centrally by the National offender Management System, for example property costs (including depreciation), major maintenance, prisoner escort and custody service and central HQ overheads. Our estimate compares to costs of: (1) £113 stated in Think Family (2010); (2) £65 (£23,700 per annum) for a male local prison stated in SEU (2002); (3) £102 (£27,343 per annum) stated in the HMPS annual report and accounts 2007-2008, Appendix 5 – Statistical Information; and (4) £99 (£36,268 per annum) in Home Office (2002). Some of these comparable figures may include indirect costs.	NOMS (2011), page 4.
Nights in police custody	£74	We assume the same unit cost for a night in police custody as for a night in prison.	N/A.

Sources:

(1) Think Family (2010), Guidance note (3), Evidence for Think Family, Think Family Toolkit, February 2010.
(2) Winsor (2011), Independent review of police officer and staff remuneration and conditions, Part I Report, March 2011.
(3) Home Office (1999), Harries, R., The cost of criminal justice, Home Office Research, Development and Statistics Directorate, Research Findings No. 103.
(4) SEU (2002), Reducing reoffending by ex-prisoners, Social Exclusion Unit, July 2002.
(5) Home Office (2002), Prison Statistics England and Wales 2002.
(6) NOMS (2011), NOMS annual report and accounts 2010-11: Management Information Addendum.

Health unit costs assumed

Service	Unit cost	Basis	Source
Visit to GP	£30	The average cost of an 11.7 minute surgery consultation. This figure excludes qualification costs of £6.	Curtis (2011), page 149.
Visit to A&E	£233	The national average cost of an accident and emergency treatment not leading to admission is £106. We have assumed that 50% of A&E visits require an ambulance. We have therefore added 50% of the cost of an ambulance call out (£127).	Curtis (2011), pages 91 and 149.
Outpatient appointment	£147	The national weighted average of all outpatient procedures.	Curtis (2011), page 91.
General contact with the community mental health team	£39	NHS reference costs figure.	Curtis (2011), page 168.
Intervention from CMHT (therapy session)	£106	We use the cost of a CBT session.	Curtis (2011), page 40.
Nights in hospital	£285	The NHS Institute for Innovation and Improvement website states that the bed day cost used by health organisations and the Department of Health is generally between £250 and £300 (in 2009 terms). This estimate includes fixed overhead costs of heating, lighting, laundry and provision of food for the patient occupying the bed, and an average cost for medicines and staff. We adopt the midpoint of this range and apply inflation. This compares to an excess bed day tariff of £308 (NHS 2011).	NHS Institute for Innovation and Improvement website.
Nights in mental health hospitals	£321	The weighted average of all adult mental health inpatient bed day costs.	Curtis (2011), page 42.

Sources:

(1) Curtis (2011), Unit costs of health and social care 2011, University of Kent.

(2) NHS Institute for Innovation and Improvement website: www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/Return_on_Investment_(ROI)_calculator.html

(3) NHS (2011), National Schedule of Reference Costs 2009-10 for NHS Trusts and PCTs Combined: Appendix NSRC04.

Drug and alcohol treatment unit costs assumed

Service	Unit cost	Basis	Source
One-to-one contact with drug /alcohol team	£54	We use the cost of a 55 minute clinic consultation with an alcohol case worker in A&E (excluding qualification costs of £7) as a proxy.	Curtis (2011), page 57.
Group contact with drug/alcohol team	£14	We use the cost of a group CBT session of two hours with twelve participants as a proxy.	Curtis (2011), page 45.
Week on substitute prescriptions	£51	Total cost of substitute prescriptions for one week.	Curtis (2011), page 56.
Nights in inpatient detox and rehab (drugs or alcohol)	£120	Curtis (2011) provides two possible reference points for the cost of a night in a detox or rehab centre: (1) The average cost of a detox unit across both NHS and voluntary organisations is £137 per night, comprising direct pay (£86), direct overheads (£15) and indirect costs and overheads (£46). (2) The average cost across 34 residential rehabilitation centres is £92 per night. We did not distinguish between detox and rehabilitation in our data collection and therefore we use the average value in our analysis.	Curtis (2011), pages 54 and 55.

Sources:
(1) Curtis (2011), Curtis, Unit costs of health and social care 2011, University of Kent.

Housing unit costs assumed

Service	Unit cost	Basis	Source
Rough sleeping	£0	We assume that there is zero cost associated with rough sleeping. In reality, lack of accommodation might result in health and crime costs to society possibly not captured in the data we have collected (for example if they do not result in a hospital appearance or police intervention).	N/A
Direct access hostel (night)	£47	We use the figure for 'homeless single people in temporary accommodation' from the Capgemini evaluation of the Supporting People Programme. This category includes people in "homeless refuge, homeless hostel, B&B or other temporary accommodation". We calculate a daily unit cost from an annual figure of £16,085 (including £8,283 support costs and £7,802 housing costs).	Ashton and Hempenstall (2009), pages 144 and 151.
Second stage supported accommodation (night)	£26	We use the figure for "homeless single people in settled accommodation" from the Capgemini evaluation of the Supporting People Programme. This category includes people in "supported lodgings, supported housing, floating support, accommodation based-service or teenage parent accommodation". We calculate a daily unit cost from an annual figure of £9,019 (which includes £4,973 support costs and £4,046 housing costs).	Ashton and Hempenstall (2009), pages 144 and 150.
Own social tenancy (week)	See right	We use the average 'eligible' rent for a one bedroom property with a Local Authority landlord: Cambridgeshire: £72.59 Derby: £61.49 Mendip: £74.00	Local Authority figures.
Own private rented sector tenancy (week)	See right	We use Local Housing Allowance rates for one bedroom properties as at February 2012. Cambridgeshire: £115.38 per week Derby: £84.23 per week Mendip: £91.15 per week	DirectGov and the Valuation Office Agency.
Room in shared private rented sector property (week)	See right	We use Local Housing Allowance rates at the single room rate (Feb 2012) Cambridgeshire: £76.19 per week Derby: £53.00 per week Mendip: £59.00 per week	DirectGov and the Valuation Office Agency.

Sources:

(1) Kenway and Palmer (2003), Single homelessness and the question of numbers and cost.

(2) Emmaus (2008), Clarke, Markkanen and Whitehead, An economic evaluation of Emmaus Village Carlton, University of Cambridge.

(3) Ashton and Hempenstall (2009), Research into the financial benefits of the Supporting People programme 2009, Capgemini, for Communities and Local Government, London.

(4) DirectGov and the Valuation Office Agency website: https://lha-direct.voa.gov.uk.

Appendix 8: Detailed service use analysis (by area)

The data shown in this appendix is for 15 clients in Cambridgeshire, 13 clients in Derby and eleven clients in Somerset. The average client participated in the pilot for seven months. Because we also have data for clients discharged from the pilot, the average period of data that we have after enrolment is slightly longer, at nine months.

We were not provided with data on all types of service use from all areas. The data not provided was: data on the use of mental health services in Somerset, data on the use of criminal justice services in the last six months of the Somerset pilot and probation data for Cambridgeshire.

All areas: Effect of enrolment in the pilot on the cost of service use (n=39)

	Cost				Service use frequency			
	Without enrolment	With enrolment	Increase / (reduction)	Monthly increase / (reduction) per client	Without enrolment	After enrolment	Increase / (reduction)	Monthly increase / (reduction) per client
	£	£	£	£				
Arrests	392,441	362,074	(30,366)	(99)	184	170	(14)	(0.0)
Attended magistrates court	92,655	90,397	(2,258)	(7)	93	91	(2)	(0.0)
Attended crown court	20,608	33,722	13,114	43	2	3	1	0.0
Other crime costs	50,396	98,186	47,789	134	N/A	N/A	N/A	N/A
Recorded offending	**556,100**	**584,379**	**28,279**	**71**	**N/A**	**N/A**	**N/A**	**N/A**
Visit to GP	3,928	3,900	(28)	(0)	131	130	(1)	(0.0)
Nights in hospital	41,027	59,412	18,385	49	144	209	65	0.2
Visited A&E	24,612	29,760	5,148	14	106	128	22	0.1
Nights in mental health hospitals	86,125	175,587	89,462	328	268	547	279	1.0
Other health and mental health costs	29,532	49,718	20,186	67	N/A	N/A	N/A	N/A
Health and mental health	**185,224**	**318,377**	**133,153**	**457**	**N/A**	**N/A**	**N/A**	**N/A**
Drug and alcohol treatment	3,633	5,124	1,491	4	260	366	107	0.3
Rehab and Detox	0	39,985	39,985	107	0	334	334	0.9
Other drug and alcohol costs	27,923	29,973	2,050	6	N/A	N/A	N/A	N/A
Drugs and alcohol	**31,556**	**75,082**	**43,525**	**117**	**N/A**	**N/A**	**N/A**	**N/A**
Nights sleeping in a direct access hostel	61,236	73,776	12,540	34	1,316	1,586	270	0.7
Nights sleeping in second stage supported accommodation	61,404	62,772	1,368	4	2,376	2,429	53	0.1
Other housing costs	74,995	130,308	55,313	56	N/A	N/A	N/A	N/A
Housing	**197,635**	**266,855**	**69,220**	**94**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**970,516**	**1,244,694**	**274,178**	**740**	**N/A**	**N/A**	**N/A**	**N/A**

Note (1): "Cost without enrolment" is the cost of service use in the year prior to entering the pilot pro-rated to the number of months clients spent in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (2): "Cost with enrolment" is the cost of service use recorded whilst in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (3): The monthly cost change is calculated as the total cost change divided by the number of client months recorded for each question. Due to occasional missing data, the number of client months varies across categories. Please see the Technical Appendix for further details.

Cambridgeshire: Effect of enrolment in the pilot on the cost of service use (n=15)

	Cost				Service use frequency			
	Without enrolment	With enrolment	Increase / (reduction)	Monthly increase / (reduction) per client	Without enrolment	After enrolment	Increase / (reduction)	Monthly increase / (reduction) per client
	£	£	£	£				
Arrests	240,495	142,700	(97,796)	(643)	113	67	(46)	(0.3)
Attended magistrates court	55,960	37,748	(18,212)	(120)	56	38	(18)	(0.1)
Attended crown court	9,367	11,241	1,873	12	1	1	0	0.0
Other crime costs	30,506	38,925	8,419	61	N/A	N/A	N/A	N/A
Recorded offending	**336,329**	**230,614**	**(105,715)**	**(689)**	**N/A**	**N/A**	**N/A**	**N/A**
Visit to GP	3,845	3,300	(545)	(4)	128	110	(18)	(0.1)
Nights in hospital	7,581	3,980	(3,601)	(24)	27	14	(13)	(0.1)
Visited A&E	8,680	9,998	1,318	9	37	43	6	0.0
Nights in mental health hospitals	63,237	124,548	61,311	403	197	388	191	1.3
Other health and mental health costs	16,489	18,337	1,848	12	N/A	N/A	N/A	N/A
Health and mental health	**99,832**	**160,162**	**60,330**	**397**	**N/A**	**N/A**	**N/A**	**N/A**
Drug and alcohol treatment	3,372	4,900	1,528	10	241	350	109	0.7
Rehab and Detox	0	0	0	0	0	0	0	0.0
Other drug and alcohol costs	16,591	20,472	3,882	26	N/A	N/A	N/A	N/A
Drugs and alcohol	**19,962**	**25,372**	**5,410**	**36**	**N/A**	**N/A**	**N/A**	**N/A**
Nights sleeping in a direct access hostel	0	15,118	15,118	99	0	325	325	2.1
Nights sleeping in second stage supported accommodation	61,404	37,291	(24,113)	(159)	2,376	1,443	(933)	(6.1)
Other housing costs	17,783	55,449	37,666	248	N/A	N/A	N/A	N/A
Housing	**79,187**	**107,858**	**28,671**	**189**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**535,310**	**524,006**	**(11,304)**	**(68)**	**N/A**	**N/A**	**N/A**	**N/A**

Note (1): "Cost without enrolment" is the cost of service use in the year prior to entering the pilot pro-rated to the number of months clients spent in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (2): "Cost with enrolment" is the cost of service use recorded whilst in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (3): The monthly cost change is calculated as the total cost change divided by the number of client months recorded for each question. Due to occasional missing data, the number of client months varies across categories. Please see the Technical Appendix for further details.

Derby: Effect of enrolment in the pilot on the cost of service (n=13)

	Cost				Service use frequency			
	Without enrolment	With enrolment	Increase / (reduction)	Monthly increase / (reduction) per client	Without enrolment	After enrolment	Increase / (reduction)	Monthly increase / (reduction) per client
	£	£	£	£				
Arrests	127,630	206,595	78,966	653	60	97	37	0.3
Attended magistrates court	30,983	46,689	15,706	130	31	47	16	0.1
Attended crown court	11,241	22,482	11,241	93	1	2	1	0.0
Other crime costs	19,794	58,433	38,640	319	N/A	N/A	N/A	N/A
Recorded offending	**189,647**	**334,199**	**144,552**	**1,195**	**N/A**	**N/A**	**N/A**	**N/A**
Visit to GP	0	0	0	0	0	0	0	0.0
Nights in hospital	21,271	32,691	11,420	94	75	115	40	0.3
Visited A&E	14,750	19,298	4,548	38	63	83	20	0.2
Nights in mental health hospitals	22,888	51,039	28,151	233	71	159	88	0.7
Other health and mental health costs	12,724	29,911	17,187	142	N/A	N/A	N/A	N/A
Health and mental health	**71,633**	**132,939**	**61,305**	**507**	**N/A**	**N/A**	**N/A**	**N/A**
Drug and alcohol treatment	252	224	(28)	(0)	18	16	(2)	(0.0)
Rehab and Detox	0	0	0	0	0	0	0	0.0
Other drug and alcohol costs	11,297	9,393	(1,904)	(16)	N/A	N/A	N/A	N/A
Drugs and alcohol	**11,549**	**9,617**	**(1,932)**	**(16)**	**N/A**	**N/A**	**N/A**	**N/A**
Nights sleeping in a direct access hostel	55,406	53,448	(1,958)	(16)	1,191	1,149	(42)	(0.3)
Nights sleeping in second stage supported accommodation	0	25,481	25,481	211	0	986	986	8.1
Other housing costs	24,054	2,337	(21,717)	(179)	N/A	N/A	N/A	N/A
Housing	**79,460**	**81,265**	**1,806**	**15**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**352,288**	**558,020**	**205,732**	**1,700**	**N/A**	**N/A**	**N/A**	**N/A**

Note (1): "Cost without enrolment" is the cost of service use in the year prior to entering the pilot pro-rated to the number of months clients spent in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (2): "Cost with enrolment" is the cost of service use recorded whilst in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (3): The monthly cost change is calculated as the total cost change divided by the number of client months recorded for each question. Due to occasional missing data, the number of client months varies across categories. Please see the Technical Appendix for further details.

Somerset: Effect of enrolment in the pilot on the cost of service use (n=11)

	Cost				Service use frequency			
	Without enrolment	With enrolment	Increase / (reduction)	Monthly increase / (reduction) per client	Without enrolment	After enrolment	Increase / (reduction)	Monthly increase / (reduction) per client
	£	£	£	£				
Arrests	24,316	12,779	(11,537)	(330)	11	6	(5)	(0.1)
Attended magistrates court	5,712	5,960	248	7	6	6	0	0.0
Attended crown court	0	0	0	0	0	0	0	0.0
Other crime costs	97	828	731	7	N/A	N/A	N/A	N/A
Recorded offending	**30,125**	**19,567**	**(10,558)**	**(315)**	**N/A**	**N/A**	**N/A**	**N/A**
Visit to GP	83	600	518	5	3	20	17	0.2
Nights in hospital	12,176	22,742	10,565	107	43	80	37	0.4
Visited A&E	1,182	465	(717)	(7)	5	2	(3)	(0.0)
Nights in mental health hospitals	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other health costs	319	1,470	1,152	N/A	N/A	N/A	N/A	N/A
Health	**13,759**	**25,277**	**11,517**	**105**	**N/A**	**N/A**	**N/A**	**N/A**
Drug and alcohol treatment	9	0	(9)	(0)	1	0	(1)	(0.0)
Rehab and Detox	0	39,985	39,985	404	0	334	334	3.4
Other drug and alcohol costs	36	108	72	1	N/A	N/A	N/A	N/A
Drugs and alcohol	**45**	**40,093**	**40,047**	**405**	**N/A**	**N/A**	**N/A**	**N/A**
Nights sleeping in a direct access hostel	5,830	5,210	(620)	(6)	125	112	(13)	(0.1)
Nights sleeping in second stage supported accommodation	0	0	0	0	0	0	0	0.0
Other housing costs	33,158	72,522	39,364	398	N/A	N/A	N/A	N/A
Housing	**38,988**	**77,732**	**38,743**	**391**	**N/A**	**N/A**	**N/A**	**N/A**
Total	**82,917**	**162,668**	**79,750**	**585**	**N/A**	**N/A**	**N/A**	**N/A**

Note (1): "Cost without enrolment" is the cost of service use in the year prior to entering the pilot pro-rated to the number of months clients spent in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (2): "Cost with enrolment" is the cost of service use recorded whilst in the pilot or, if discharged, the time between enrolment and the end of the study.
Note (3): The monthly cost change is calculated as the total cost change divided by the number of client months recorded for each question. Due to occasional missing data, the number of client months varies across categories. Please see the Technical Appendix for further details.
Note (4): Somerset offending data for the last six months and mental health data could not be collected so is not included in this analysis.

Appendix 9: The Warwick-Edinburgh Mental Well-being Scale

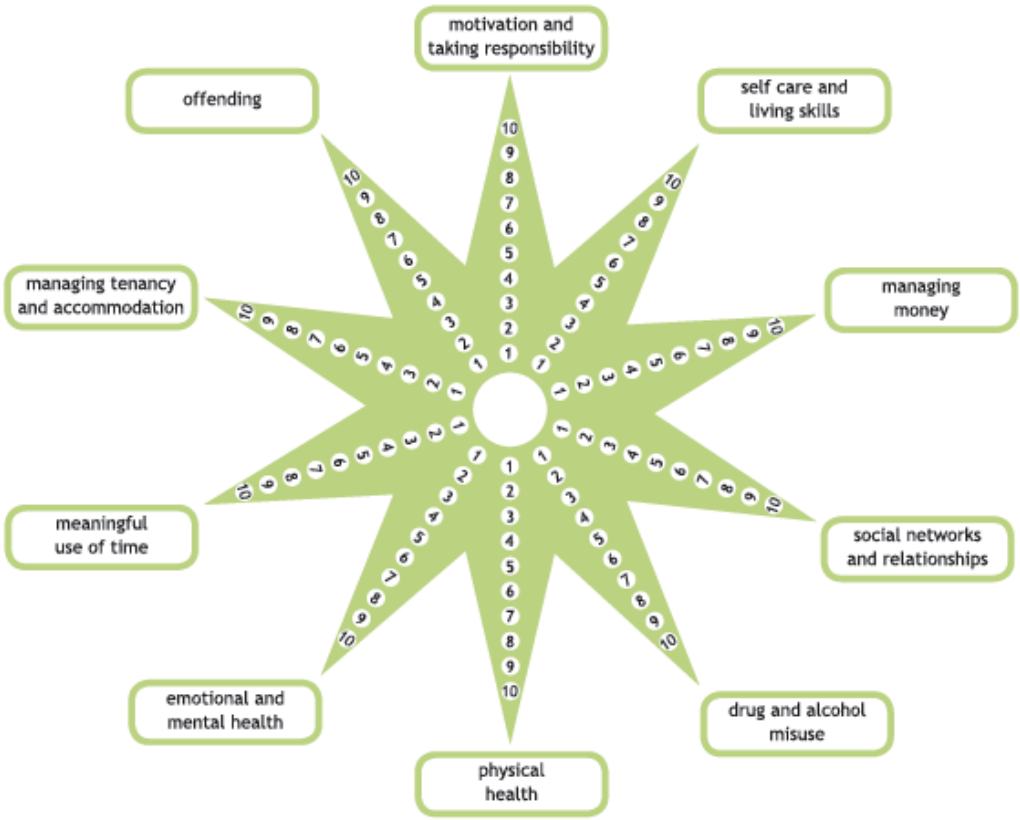
Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

Appendix 10: The Outcomes Star™ assessment

The diagram below illustrates the components of the Outcomes Star™ assessment. For further information, please see the user guide to the Homelessness Outcomes Star™, available online at:
www.outcomesstar.org.uk/homelessness



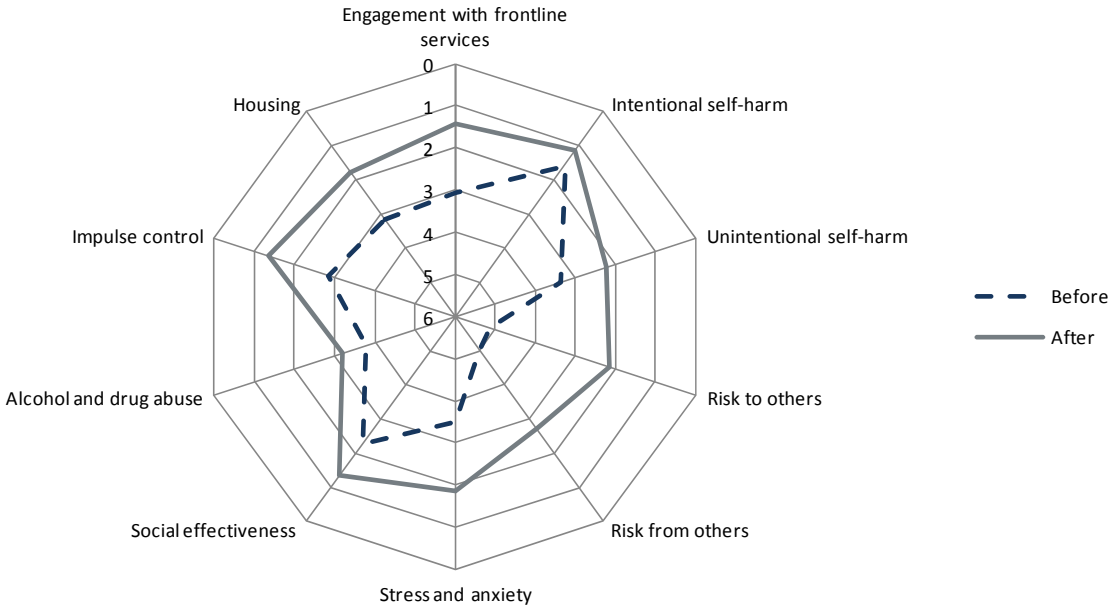
Appendix 11: Wellbeing results for the Cambridgeshire pilot

In Cambridgeshire:

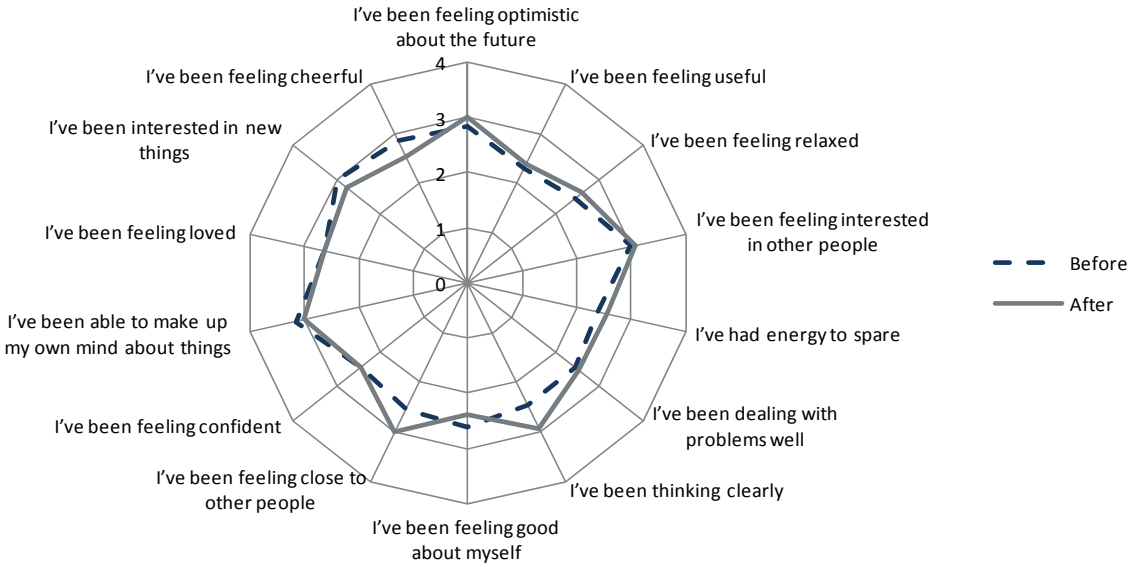
- average NDT scores improved from 34 to 19;
- average WEMWBS scores improved from 37 to 38; and
- average Outcomes Star™ scores improved from 43 to 58.

The diagrams below show these improvements.

Cambridgeshire NDT scores (n=14)

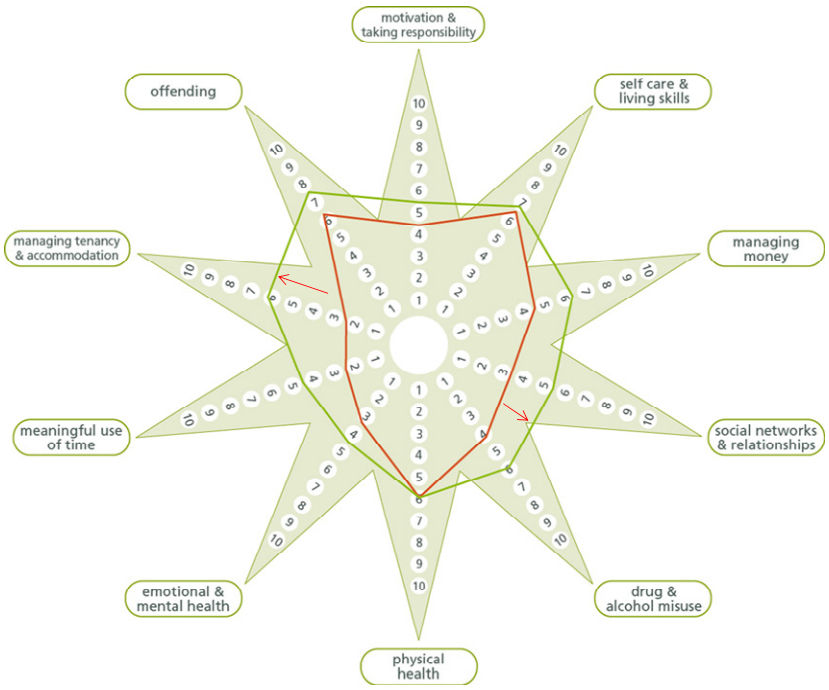


Cambridgeshire WEMWBS scores (n=13)



In Cambridgeshire, there has been only a slight improvement in WEMWBS scores. It has been suggested that clients who have started to address some of their problems can sometimes score less well on wellbeing assessments than before they accessed services. The Cambridgeshire service coordinator believes that the Cambridgeshire clients now have an increased perception of the severity of their current situation and that this may have limited reported improvements in wellbeing on the WEMWBS measure.

Cambridgeshire Outcomes Star™ scores (n=14)



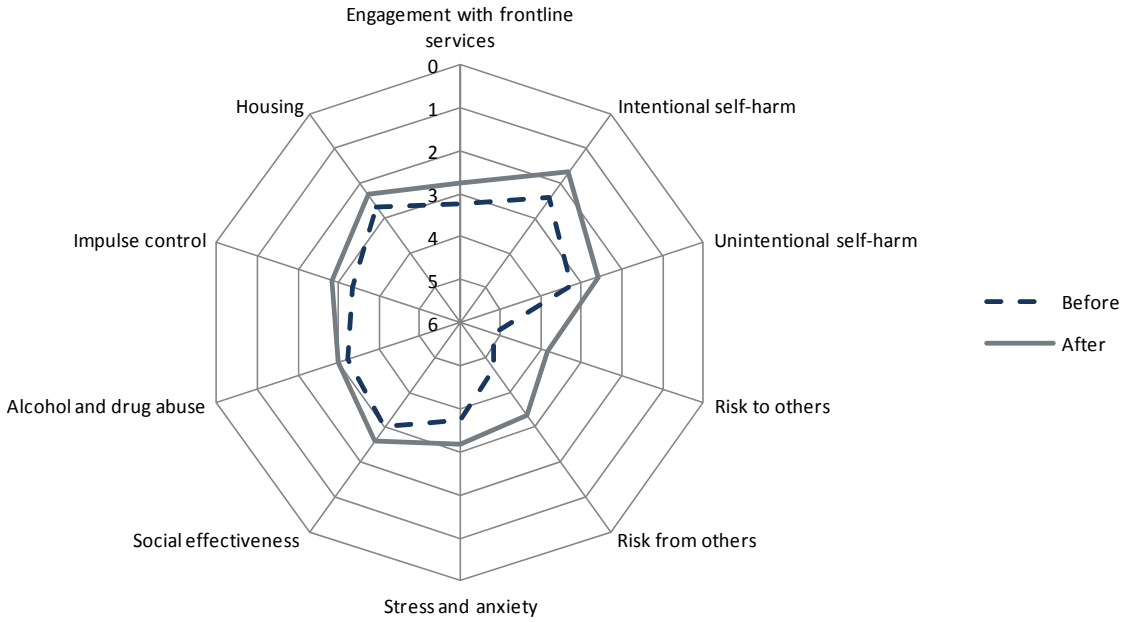
Appendix 12: Wellbeing results for the Derby pilot

In Derby:

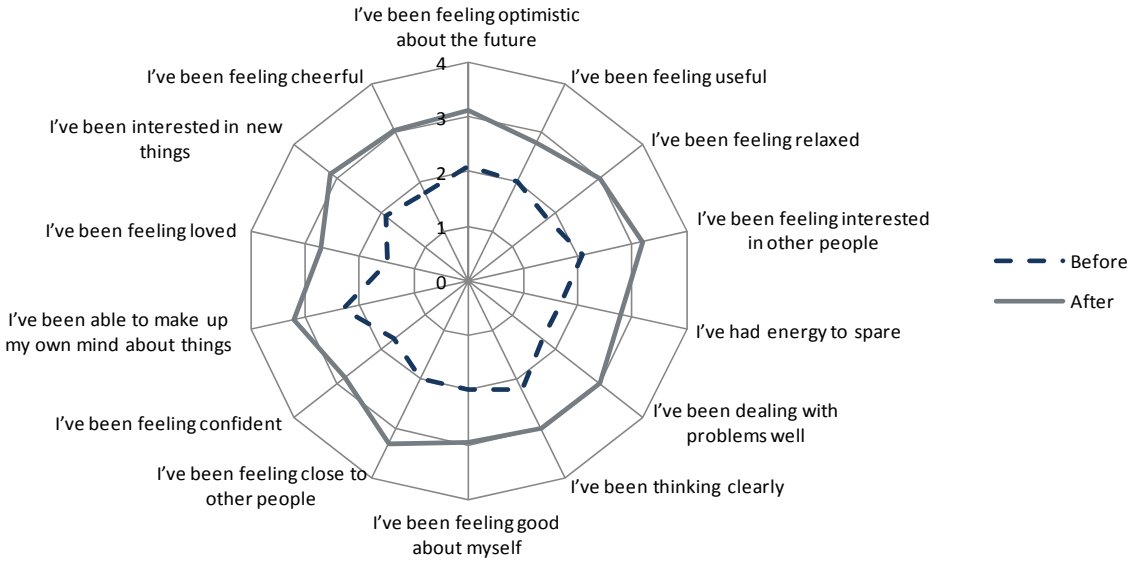
- average NDT scores improved from 35 to 28;
- average WEMWBS scores improved from 27 to 42; and
- average Outcomes Star™ scores improved from 39 to 60.

The diagrams below show these improvements.

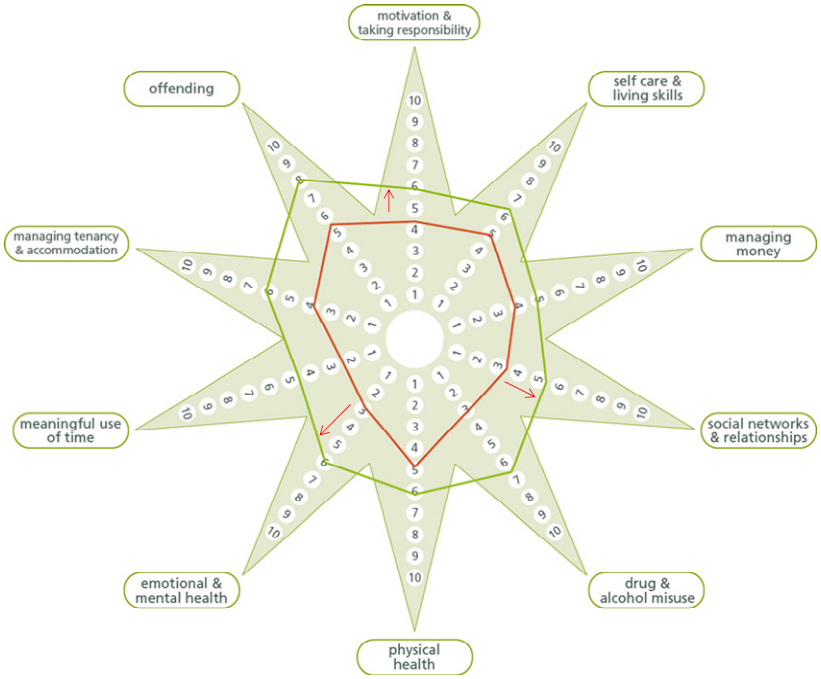
Derby NDT scores (n=12)



Derby WEMWBS scores (n=10)



Derby Outcomes Star™ scores (n=7)



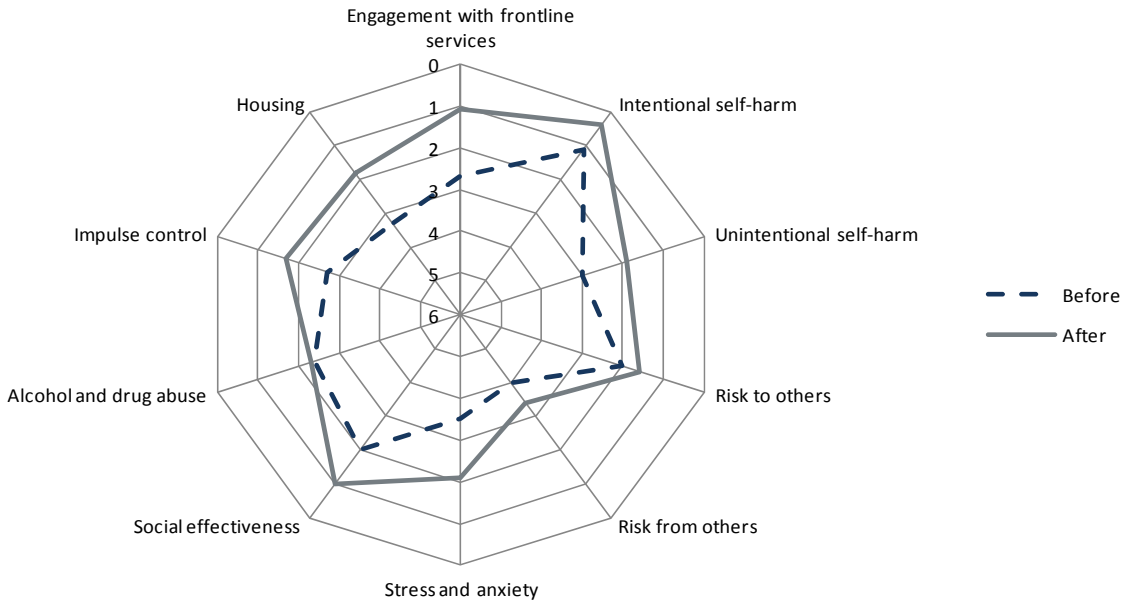
Appendix 13: Wellbeing results for the Somerset pilot

In Somerset:

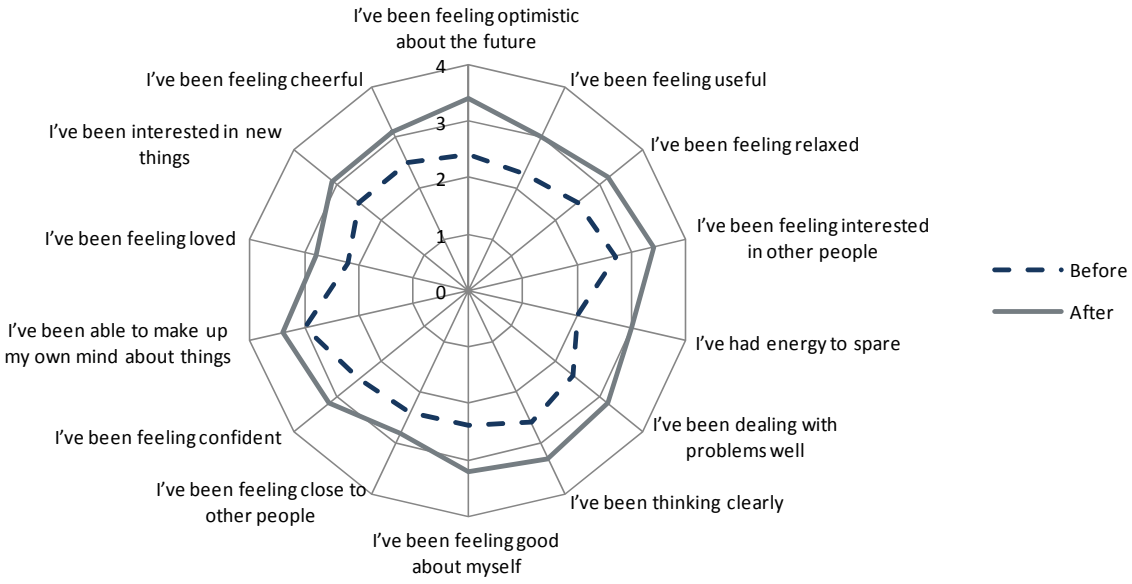
- average NDT scores improved from 27 to 17;
- average WEMWBS scores improved from 34 to 44; and
- average Outcomes Star™ scores improved from 44 to 63.

The diagrams below show these improvements

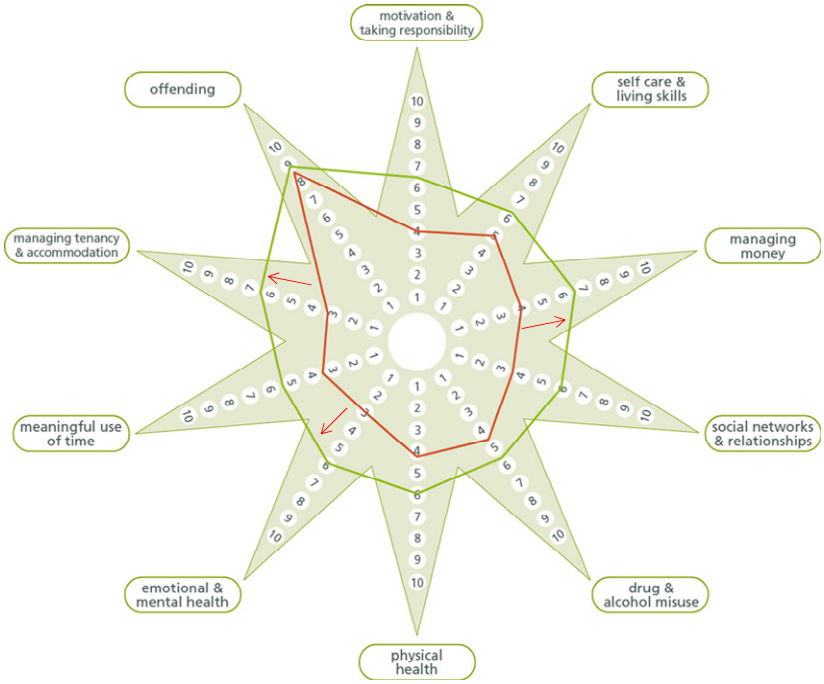
Somerset NDT scores (n=10)



Somerset WEMWBS scores (n=10)



Somerset Outcomes Star™ scores (n=10)



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Pro Bono Economics (PBE)

PBE has supported this work as part of its mission to help charities measure their performance better and demonstrate the results of their work. The views expressed in this report are not necessarily those of PBE.

PBE matches volunteer economists with charities wishing to address questions around measurement, results and impact. Through this PBE hopes to achieve two objectives:

(1) improved effectiveness of the charity sector; and

(2) a valued contribution by economists both to the sector and to their professional development.

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One of the world's leading economic consulting firms, Compass Lexecon provides law firms, corporations and government clients with clear analysis of complex issues. We have been involved in a broad spectrum of matters related to economics and finance – providing critical insight in legal and regulatory proceedings, strategic decisions and public policy debates.

Making Every Adult Matter (MEAM)

Making Every Adult Matter (MEAM) is a coalition of four national charities – Clinks, DrugScope, Homeless Link and Mind – formed to influence policy and services for adults facing multiple needs and exclusions. Together the charities represent over 1,600 frontline organisations working in the criminal justice, drug treatment, homelessness and mental health sectors. MEAM is supported by the Calouste Gulbenkian Foundation.