UNIVERSITY OF
LINCOLN

NOTTINGHAMSHIRE RSI AND RRP EVALUATION

Report for: **Ashfield District Council (lead) and Nottinghamshire Local Authorities**

July 2021

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The University of Lincoln

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Contents:

Nottinghamshire Rough Sleeping Initiative (RSI) and Rapid Rehousing Pathway (RRP) Evaluation: Final Report

Acknowledgements:

The research team would like to thank the considerable number of people who contributed to and made this evaluation possible. In particular we would like to thank the more than thirty individual staff members from the range of projects, and a similar number of service users who went out of their way to be available for a remote interview, and /or focus group participation, or to complete a detailed questionnaire. Special thanks to members of the Steering Group for valuable input and steering of the project at each stage – Alison Bennett, Emma Lindley, Nick Romilly, Niki Dolan, Eleanor Hedley, and Jon Leighton.

The team also want to thank Frances Pearson and Sarah Rollitt at the University of Lincoln for administrative support.

Glossary of Terms:

A&E	Accident and Emergency
CBO	Criminal Behaviour Orders
CGL	Change Grow Live
CPN	Community Psychiatric Nurse
DASH	Decent and Safe Homes
DWP	Department for Work and Pensions
ESOL	English for Speakers of Other Languages
FTE	Full-time equivalent
GDPR	General Data Protection Regulation
GP	General Practitioner
HCPC	Health and Care Professional Council
HF	Housing First
HMP	Her Majesty's Prison
MHCLG	Ministry of Housing, Communities and Local Government
NICE	National Institute for Clinical Excellence
OMF	Outcomes Monitoring Framework
NPRS	Nottinghamshire Prevention and Resettlement Service
PCSO	Police Community Support Officer
PDU	Professional Development Unit
PPE	Personal Protective Equipment
PTSD	Posttraumatic Stress Disorder
RSAG	Rough Sleepers Action Group
RSI	Rough Sleepers Initiative
RRP	Rapid Rehousing Pathway
SOT	Street Outreach Team
SPSS	Statistical Package for the Social Sciences
SU	Service User
UC	Universal Credit
YMCA	Young Men's Christian Association

Executive Summary

Introduction

We, at the University of Lincoln, were commissioned in December 2020 to design and conduct a piece of research to address the following question.

"***To identify how to most effectively design, deliver and evaluate/monitor services provided to those currently/with a history of/at risk of rough sleeping, taking a whole system approach, to achieve the vision of ending rough sleeping in Nottinghamshire."***

Within this overarching aim, there were four specific questions that we were asked to address:

a. What does the theory and evidence base (nationally and internationally) identify as the critical success factors in supporting those currently or at imminent risk of rough sleeping? What are the outcomes of this support?
b. What are the critical success factors of the Nottinghamshire RSI and RRP interventions and how do these compare to those identified above?
c. What outcomes are delivered by the Nottinghamshire RSI and RRP interventions and how do these compare to those identified above?
d. Based on the above, recommend a framework of key principles and outcomes that RSI and RRP services should operate under, as well as a methodology to evaluate delivery of these.

The first of those questions, regarding the existing theory and evidence base is fully addressed in a separate rapid review of the literature, which should be read alongside this report.

Methodology

The methodology adopted allowed us to explore perspectives of both staff and people accessing services and to provide a nuanced and detailed understanding of each perspective, as well as highlighting variations in perspective which may need further exploration and may inform future service development. Questionnaires provided an overall picture about the health and outcomes of the homeless population in Nottinghamshire, and qualitative interviews enabled construction of a rich and detailed picture of outcomes for individuals. The research was approved by the University of Lincoln Research Ethics Committee (Reference: 2020_3871).

We completed two focus groups, with six participants each to gather initial themes in relation to success factors and outcomes across services. The findings from the focus groups were utilised to inform semi-structured one-to-one interviews with (n=26) staff across services, including managers and operational practitioners, and included individuals working at the following services: CGL (Change, Grow, Live), Ashfield District Council, Mansfield District Council, Framework Housing Association, DASH (Decent and Safe Homes), Newark and Sherwood District Council, Sherwood Forest Hospital NHS Trust, YMCA, CPN Assertive outreach, Action Housing, Tuntum Housing Association and private landlords.

Individual interviews were conducted on the telephone with (n=12) individuals who have recently accessed or are currently accessing a range of services. Recruitment ensured representation from diverse groups including, as far as possible, people from ethnic minority groups, women, those who have been involved with the criminal justice system, and individuals who have been homeless for varying lengths of time. Each participant received a £20 Greggs voucher for their participation. Each one-to-one interview lasted approximately 30-60 minutes and was conducted by one researcher. A detailed set of questions were asked of each participant covering: living arrangements over past five years, physical and mental health, finances, relationships, crime, support needs and feedback about services.

Analysis of data

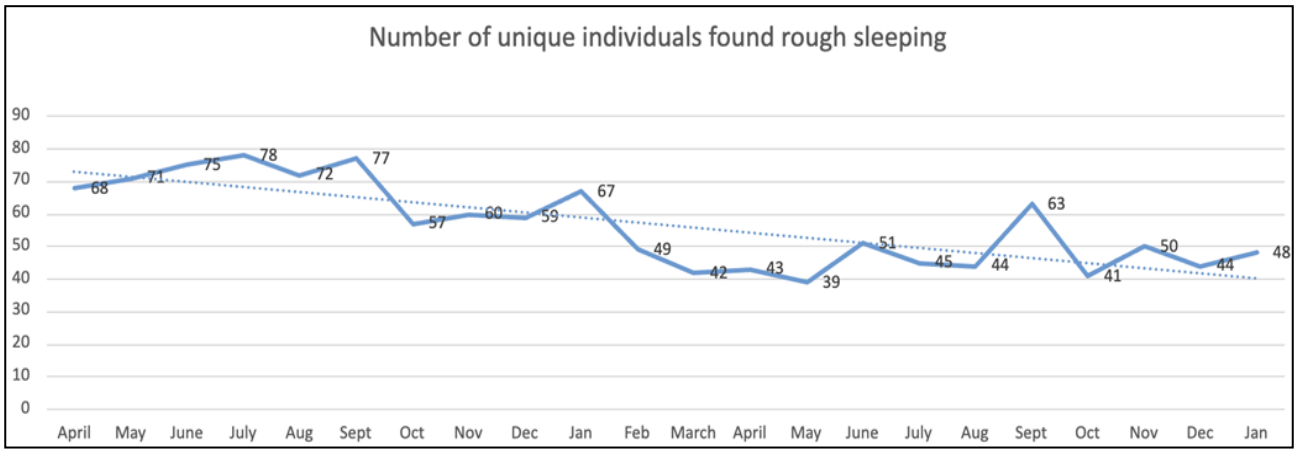
Analysis of the quantitative data from questionnaires was undertaken using statistical software (IBM SPSS). Thematic analysis was used to assess the data set gathered from both the focus group and individual interviews (staff and service users) together. This approach is suited to questions relating to people's experiences and to the ways in which people construct meaning from their experiences. Its purpose is to identify patterns of meaning across a data set. This approach led to the identification of themes, and in relation to each theme we highlight key outcomes and critical success factors.

COVID-19 Restrictions

All parties were keen that rough sleepers would be spoken to directly as part of the evaluation, and initial plans were made to visit Nottinghamshire for this purpose. Because of ongoing COVID-19 restrictions and concerns, it was not possible to do this in a way that would not increase risk. We were able to speak to several service users via telephone or video link and whilst the numbers were less than initially anticipated we were able to gather some in depth accounts from service users to inform and complement the views of staff.

Results

Our own findings and those from regular monitoring support the findings from national data which show that these programmes are successful in terms of reducing rough sleeper numbers. Recent data from routine monitoring reports suggest that these numbers have reduced steadily as projects have developed.



Number of individuals found rough sleeping by street outreach teams in Nottinghamshire since April 2019 – January 2021. Source: RSI and RRP routine monitoring data.

Beyond the headline of rough sleeper numbers there are a range of other interesting findings which will be useful in planning and shaping future service provision. From the qualitative data, we established 14 themes and 42 sub themes.

Theme 1: RSI context

- The reasons for homelessness amongst people accessing RSI services were diverse, and often complex. There appeared to be some differences in the perceptions between staff and service users. For example, service users most often reported homelessness due to family breakdown or issues in the family home, including overcrowding, while staff reported reasons relating to behaviour and finances.
- In addition to the complexities around reasons for people becoming homeless, there was also a prevalent sub-theme around the difficulties of moving from street homelessness. Whilst some of this was relating to the need for the right type of accommodation (see also section on accommodation), there was recognition from staff that involvement in criminality mean that some people felt trapped on the streets.
- The support needs of people living on the streets and accessing RSI services are complex and diverse. Their needs can mean increased use of Blue Light Services. When people were on the streets, even when supported, there appeared to be issues around access to basic provisions such as food and washing facilities and there were suggestions that this could be improved.
- The network of services delivered across RSI meant that activities undertaken, and outcomes achieved were hugely varied. Some of the outcomes were more traditional hard outcomes such as gaining or maintaining accommodation, and dealing with practical issues such as appointments, benefits, and bills. Other outcomes were soft outcomes such as increased independence and empowerment, which cannot necessarily be directly quantified.
- Most of the local authorities in the county convene a regular Rough Sleeper Action Group that is attended by multiple agencies to share intelligence on cases and agree a joint action plan of support for rough sleepers. These are attended by many of the partners in the RSI/RRP projects, as well as DWP, Probation, Adult Social Care, Police Bassetlaw, Mid Nottinghamshire, and Greater Nottingham CCGs. Gedling hosts a bespoke MDT instead. The meetings are highly valued by most participants that we spoke to.

Theme 2: Mental Health

- The importance of support and interventions in relation to the mental health of service users was one of the most frequent themes highlighted by participants.
- Many rough sleepers have serious and long-standing mental health problems, and many remain undiagnosed.
- Supporting those discharged from mental health services, to prevent them becoming rough sleepers was noted as important and successful.
- Similarly, providing rapid and effective support via street outreach from a mental health professional was valued and seen as highly effective.

Theme 3: Trauma

- Experience of trauma is widespread in this population and many respondents confirmed this.
- Trauma is a key issue which needs to be addressed, in order for individuals to achieve successful outcomes.
- Trauma can take many forms. The most common type of trauma in our survey was a result of being the victim of domestic abuse.

Theme 4: Substance Use

- As highlighted in the literature review, substance use plays a key role in the lives of rough sleepers. The use may predate the rough sleeping or be a response to the harshness of sleeping on the streets.
- Again, the street outreach approach was highlighted as especially useful as an approach leading to successful outcomes.
- Successful outcomes often require getting specialist substance use support for people.
- Some participants suggested that there does need to be more accessible provision of specialist treatment rehab facilities and that the criteria for being accepted onto the pathways for rehab are sometimes unrealistic.
- It remains almost impossible to secure private rented accommodation for those with drug use issues.

Theme 5: Complex Needs

- The complexity referred to by this title can refer to a range of diverse needs but often includes mental health and substance use, as well as experience of trauma, experience of being in prison, family breakdown, and several others.
- Those with ‘complex needs’ may pose the greatest challenges in terms of a service response. They are also the group who may particularly need intense, ongoing, and specialist support if they are to remain successfully housed.
- Dual diagnosis is very prevalent in the populations that the projects are working with. The routine data completed by the CPN employed in the street outreach suggests that all the clients had co morbid substance misuse as well as mental health problems.

Theme 6: Physical Health

- Unmanaged wounds and skin care issues were very prevalent, as were respiratory problems.
- The Nurse practitioner also highlighted unmanaged diabetes as a significant issue.
- Interviews with service users highlighted the following range of physical health problems: Alopecia, heart defects, COPD, kidney failure, cancer, broken bones, slipped discs, diabetes, hepatitis C and physical disabilities.

Theme 7: Relationships

- Multi-agency working was viewed as an over-riding success factor resulting from the RSI and RRP network because it facilitated information sharing, the sharing of ideas and problem-solving approaches, and it supported the sharing of the skills, knowledge, and experience of staff across the services.
- Multi-agency working facilitated relationship-building with people being supported because support could be led, at least initially, by the professional who had the best working relationship with the person.
- The complexity of building relationships with people supported was recognised and the importance of allowing time, taking a flexible approach, and operating a person-centred approach to build trust was highlighted.
- The importance of involving families in support, where appropriate, was highlighted and could be used to help facilitate successful outcomes.

Theme 8: Accommodation

- There was a clear view that some of the most intensive support was required after someone was accommodated and that often, being accommodated brought with it a new set of challenges. Sometimes these challenges resulted in repeat cycles of rough sleeping.
- When people moved into supported accommodation, there was a recognition that the intensity of support offered through the RSI and RRP pathways lessened, and people who had previously been rough sleeping, who still required intensive support, fell into the remit of mainstream services. This was seen as a missed opportunity and the suggestion was that the intensity of support and priority access should continue once a person moved into supported accommodation to improve the chances of continued success.
- There were multiple barriers to private rented accommodation including the need for guarantors, misperceptions about people receiving benefits and costs and it was felt that private rented accommodation was not appropriate for many people who had been rough sleeping.
- Pets were recognised as an important factor and while having a pet could be a barrier to accessing accommodation, it was highlighted that asking someone to give up their pet was not appropriate.
- There were multiple perspectives on shared accommodation. For some people shared accommodation seemed suitable and could, at times, be the only option due to cost and availability. However, for many people it was unsuitable due to factors such as mental health problems and safeguarding issues.
- There were also barriers to other types of accommodation due to 'burnt bridges' such that the many options that initially appeared available were often not available on further exploration. Housing association properties could be problematic and there were variations in local authority responses.
- There were widespread calls for more complex needs accommodation with 24-hour on-site support.

Theme 9: Personal Budgets

- In terms of success factors, several participants highlighted how well personal budgets had worked for several individuals.
- Personal budgets were used frequently when available to support individuals to furnish housing, and to purchase goods and activities to support mental health.
- The ability to access funds quickly and to be able to use funds flexibly to meet individual needs were highlighted as particularly useful.

Theme 10: Landlord Support

- Landlord support and liaison was provided via two main pathways: the Call B4 You Serve service in which the landlord was the client, and the Landlord Liaison Service which aimed to source tenancies and support the transition into accommodation.
- Both services provided valuable reassurances, mediation, and information to landlords. This support resulted in increased opportunities for private rented accommodation, reduced evictions, and reduced court processes and associated costs.

Theme 11: RSI and RRP Network

- The Street Outreach Team (SOT) were a fundamental part of bringing organisations together to support people who were rough sleeping. Their flexible, assertive outreach approach, and their accessibility by phone was viewed positively. They were a vital communication link to local authorities and other housing providers and were able to provide or facilitate access to important basic resources including someone to talk to, food and hygiene provisions. The Change, Grow, Live (CGL) assertive outreach integrated with the Street Outreach Team supported faster access to services to support substance misuse needs which subsequently facilitated faster access to accommodation.
- The Nottinghamshire Prevention and Resettlement Service (NPRS) had multi-skilled practitioners working across several pathways including hospital and prison discharge, and specialist tenancy-related floating support. This provided improved communications, a single point of access and seamless support through transitions from institutions. The wider NPRS team provided preventative support to reduce future homelessness through practical and emotional support. There were no barriers to access relating to risk or need but there were some issues with capacity such that the new general tenancy support had already started to accrue a waiting list. However, it was recognised that people on the waiting list were still able to access support from other services within the RSI and RRP network.

- The Housing First model was operating within one local authority area (Mansfield). This was a relatively new service and so could not be evaluated but was operating under the key principles of Housing First including intensive support with small staff to client ratios; access to funding; and a bespoke, needs-led, person-centred approach.

Theme 12: Foreign National Group

- Clients with no recourse to public funds are at high risk of homelessness and destitution because they cannot access mainstream housing, welfare benefits and employment.
- Sometimes incorrect assumptions had been made that an individual had no recourse to public funding. Staff were working hard to secure settled status and access to public funds for as many eligible individuals as possible.
- Authorities need to consider carefully how best to continue to support those who remain without recourse to public funds.
- Providing translation and language support assist in identifying eligibility for public services and also in accessing a wider range of support.

Theme 13: Staffing

- Services work well which are co-produced and have ongoing input and feedback from service users and experienced frontline staff.
- Buddy systems are recommended to support staff welfare.
- Ongoing training for all staff in areas which have to be dealt with on a daily basis, is recommended. This includes mental health, trauma informed care and support, and substance abuse.

Theme 14: COVID-19 Impact

- The 'Everyone In' scheme worked very well to bring people off the street. Some went on to be successfully rehoused and to access other services.
- Some individuals returned to the streets because of a lack of ongoing support, or the inability or lack of readiness to cope with being housed.

Conclusion

The projects funded by RSI and RRP are generally working well individually and collectively. Many of the factors which the literature review indicated as successful nationally and internationally are now being offered in Nottinghamshire and are proving successful here in reducing rough sleeping and in leading to a range of other good outcomes. These include street outreach, intensive support, personal budgets, landlord support, the use of navigators, and rapid access to support in relation to mental health and substance use. Some elements were too new for us to be able to assess their contribution fully.

Looking to the future, our report concludes with a detailed recommended framework for data collection and ongoing evaluation.

Recommended framework for data collection and ongoing evaluation

- A multi-dimensional outcome monitoring framework is suggested to capture the breadth and depth of activity across RSI and RRP services. The framework has three main elements: Public services data; Service level outcomes monitoring; and Individual level outcomes monitoring.
- Public services data includes contacts with emergency departments, criminal justice, and mental health services.
- Suggestions for service level monitoring are designed to provide data across the pathways supported by RSI and RRP Services. The outcomes suggested are based on the pathways to reducing offending which have previously been adopted by criminal justice and allied agencies, integrated with the findings from this evaluation.
- To account for the nuances across RSI and RRP services, and for the varying pathways that people may take through the services, an individual level outcomes monitoring framework is also proposed.

1. Introduction

We, at The University of Lincoln, were commissioned in December 2020 to design and conduct a piece of research to address the following question.

"*To identify how to most effectively design, deliver and evaluate/monitor services provided to those currently/with a history of/at risk of rough sleeping, taking a whole system approach, to achieve the vision of ending rough sleeping in Nottinghamshire."*

Within this overarching aim, there were four specific questions that we were asked to address:

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The first of those questions, regarding the existing theory and evidence base is fully addressed in a separate rapid review of the literature, which should be read alongside this report. The focus in this report is on projects in Nottinghamshire which are funded by the Rough Sleeper Initiative and the Rapid Rehousing Pathway. In order to compare outcomes and success factors in Nottinghamshire, with those reported elsewhere, relevant literature will be referred to throughout this report.

The current version of the Rough Sleeper Initiative (RSI) was launched in 2018, and initially targeted at authorities with the most numbers of people sleeping rough (MCHLG, 2018). It was modelled on similar successful programmes which operated in the 1990s. The Ministry of Housing, Communities and Local Government (MCHLG) initiatives now provide funding to hundreds of local authorities across the country for projects which help to reduce rough sleeping in a range of different ways. The 2018 Rough Sleeping strategy published by the government, also introduced the Rapid Rehousing Pathway (RRP) as an important part of the overall strategy which aims to halve rough sleeping by 2022 and further eliminate rough sleeping by 2027. The RRP approach means that:

"If a person is at risk of rough sleeping, they will have their needs assessed quickly in line with the requirements of the Homelessness Reduction Act 2017, be offered appropriate support and then helped rapidly into a home, with appropriate support alongside" (MCHLG, 2018).

The eight district, borough and county councils of Nottinghamshire successfully bid for RSI and RRP funds in 2019 and 2020 and in the latter part of 2020 had a mix of established and still developing projects.

1.1. About the RSI and RRP Services

The RSI projects and initiatives which are the subject of this evaluation include: Street Outreach Team (SOT), provided by Framework Housing Association; substance misuse outreach, provided by Change, Grow, Live (CGL); support from a Tissue Viability Nurse, provided by Sherwood Forest Hospitals NHS Trust; and access to a Community Psychiatric Nursing Service, delivered by Nottinghamshire Healthcare NHS Trust. The RRP projects include: 'Call Before You Serve' (a landlord support service), provided by DASH; Landlord Liaison services, provided by local authorities and Nottingham Community Housing Association; the Nottinghamshire Prevention and Resettlement Service, provided by Framework; specialist housing for individuals with complex needs, provided by the YMCA; and Housing First Support provided by Action Housing. Rough Sleeper Action Groups (RSAGs) were set up in each authority to help coordinate services and to discuss individual cases in each area. These were also part of the evaluation. The RSI and RRP Services are overseen by a Co-Ordinator responsible for strategic oversight.

The SOT provides a core service to support the welfare of people who are rough sleeping, covering all local authority areas, with a minimum of one outreach worker per area per week. A qualified HCPC registered Social Worker is also embedded within the SOT. The team are frequently accompanied by Substance Misuse Assertive Outreach Workers from CGL. They are able to provide support in relation to harm reduction, accessing scripts and general advice. This service exists across all local authority areas, except Bassetlaw due to funding. The Assertive Community Psychiatric Service also works closely with the SOT, on a countywide basis. This has been reduced from 2.6 FTE to 1.0 FTE, but the CPN is able to facilitate the development and delivery of mental health support plans and communications with the crisis services. To address physical health needs such as wound care, a Tissue Viability Nurse also works on a countywide basis and provides satellite clinics on Mansfield. Ashfield and Bassetlaw. This includes liaison with GP surgeries to reduce barriers to access.

The Nottinghamshire Prevention and Resettlement Service (NPRS) comprises a team of 'navigators' serving a variety of functions and working countywide. Within the team there are four general navigators who offer needs-led support to people within their tenancies. The team also has one specialist prison navigator to support the transition out of prison custody through liaison and joint working with prisons and probation services, and one specialist mental health and hospital navigator who liaises and works with mental health services and hospitals.

Specialist complex needs accommodation is provided by the YMCA, covering Mansfield and Ashfield. A total of 42 units are provided across the two areas. Housing First accommodation support is provided by Action Housing in 10 local authority and private rented housing units.

The engagement with landlords occurs through two main pathways:

1. Landlord Liaison Officers (LLOs): who work to secure private rented properties for people requiring accommodation. Four LLOs work across the county.

2. Call B4 You Serve Officers: who liaise with landlords to mediate between them and their tenant to try to resolve issues that may otherwise result in eviction. In this service, a key feature is that the landlord is the client, not the tenant. There is one DASH Officer delivering this support countywide.

With this network of services, service users could take several pathways through services. This is illustrated in Figure 1 (see Appendix 3). Example pathways are as follows:

1. Call B4 You Serve pathway: Landlord contacts officer to express concern with tenancy, officer liaises and mediates between landlord and tenant; if needed officer refers tenant into other services such as NPRS or supported accommodation. Tenancy is maintained or landlord is supported to end tenancy, as appropriate.

2. Landlord liaison pathway: Service user presents to local authority as homeless but is not deemed priority need or has been found intentionally homeless under The Housing Act (1996). The LA refers to service user to the LLO for the area who will work with them to find a suitable private tenancy either in single accommodation or in shared accommodation. Initial resettlement support is provided by the LLO to set up the home but if the service user requires ongoing support, the LLO can refer to the NPRS team.

3. Rough sleeper pathway: Service User is referred to, or found by, the SOT. While homeless, they can access support from the SOT, as well as the CPN, social worker, CGL and tissue viability nurse, dependent upon needs. The outreach services work with the local authority and providers of supported accommodation to help find suitable accommodation. Accommodation could be within supported housing, external to RSI and RRP services, within Housing First accommodation, within the YMCA multiple, complex needs accommodation, within local authority accommodation, within housing association accommodation or within the private rented sector. If the accommodation is unsupported, the rough sleeper services may also refer the person for ongoing support from the NPRS Team.

4. Mental health hospital leaver pathway: A person admitted to an acute ward of a psychiatric hospital is identified as having a housing-related need and referred to the navigator. The navigator liaises with the local authority, local housing providers and the discharging hospital to try to ensure suitable accommodation and to support the transition from the hospital into accommodation. If accommodation cannot be sourced, the person may move onto the rough sleeper pathway. If accommodation can be

sourced but the service user requires additional ongoing support, they may be referred to the NPRS team.

5. Prison leaver pathway: Referrals made by prison or probation staff to navigator (or known to navigator prior to entry into custody). Navigator liaises with prison and probation staff to see if suitable accommodation is available for release. If accommodation is not available, the navigator works with housing providers and local authority to try to source accommodation. If sourced, the navigator is able to meet in person on release and help them get set up in their accommodation. If a service user is homeless on release, the navigator will continue to work with them until accommodation is found.

6. NPRS prevention pathway: NPRS may become involved after someone has experienced homelessness and has secured accommodation, as outlined in the above pathways. However, they may also become involved at an earlier point if a person is having difficulties managing their tenancy. Both entry points aim to prevent initial homelessness or repeat occurrences of homelessness.

The list provided is not exhaustive and some service users may repeat pathways on multiple occasions, such that the pathways are not always linear.

2. Methodology

The methodology outlined below allowed us to explore the wider context of service delivery before we could seek a detailed understanding of what works well and why, and how what works can be adopted as good practice across services, as well as what does not work well and why and how this can be improved. The investigation of the perspectives of both staff and people accessing services provided a nuanced and detailed understanding of each perspective, as well as highlighting variations in perspective which may need further exploration and may inform future service development. Questionnaires provided an overall picture about the health and outcomes of the homeless population in Nottinghamshire, and qualitative interviews enabled construction of a rich and detailed picture of outcomes for individuals. The research was approved by the University of Lincoln Research Ethics Committee (UoL 2020_3871).

2.1. Focus Groups

Two focus groups were facilitated online via Microsoft Teams with (n=6) service staff in each, to gather initial themes in relation to success factors and outcomes across services. Each focus group lasted approximately 120 minutes and was conducted by two researchers. The focus group questions are detailed below:

Q. What is it like working on this project?
Q. What outcomes do you support people to achieve? How?
Q. What barriers are there to supporting people to achieve their outcomes?
Q. How does this project differ from other homelessness projects?
Q. What is working well so far in this project?
Q. What is working less well so far in this project?
Q. What is it like to work with such a population in general?
Q. What do you do to support yourselves, and to take care of your own mental health?
Q. What support networks do you have in place?

2.2. One-to-One Staff Interviews

The findings from the focus groups were utilised to inform semi-structured one-to-one interviews with (n=26) staff across services, including managers and operational practitioners and included individuals working at the following services: CGL (Change Grow Live), Ashfield District Council, Mansfield District Council, Framework Housing Association, DASH (Decent and safe homes), Newark and Sherwood District Council, Sherwood Forest Hospital NHS Trust, YMCA, CPN Assertive outreach, Action Housing, Tuntum Housing Association and private landlords. One-to-one interviews typically lasted 60-120 minutes. The initial questions are detailed below:

Q. What is your role within the project?
Q. What is it like working on this project?
Q. What do you think works well?
Q. What do you think works less well?
Q. What outcomes/progression is achieved with people being supported?
Q. What do you think would improve outcomes for service users?
Q. How has Covid-19 impacted on service delivery?
Q. How do you look after yourself during your work and how important is this to continued delivery?
Q. Is there anything else you would like to add the discussion?

2.3. One-to-One Service User Interviews

Individual interviews were conducted on the telephone with (n=12) individuals who have recently accessed or are currently accessing a range of services. Recruitment ensured representation from diverse groups including, as far as possible, people from ethnic minority groups, women, those who have been involved with the criminal justice system, and individuals who have been homeless for varying lengths of time. Each participant received a £20 Greggs voucher for their participation. Each one-to-one interview lasted approximately 30-60 minutes and was conducted by one researcher. A detailed set of questions were asked of each participant covering: living arrangements over past five years, physical and mental health, finances, relationships, crime. A full set of question is listed in Appendix 1.

2.4. Quantitative Questionnaire

We issued a quantitative questionnaire in the post and via email to (n=19) individuals people accessing the services. The questionnaire served the purpose of gathering key data about services accessed, perceptions of success, reasons for homelessness, prevalence of physical health issues, mental health issues, access to health-related support, prevalence of addictions, debt, experience of crime and family contact. Each participant received a £5 Greggs voucher for their participation. Please see Appendix one for the full questionnaire. The summary of data from the questionnaire responses is given below in Table 1.

Table 1: Quantitative sample summary.

Demographic	**% (n)**
Gender	
Male	**57.9** (11)
Female	**42.1** (8)
Local authority	
Bassetlaw	**52.6** (10)
Mansfield	**36.8** (7)
Ashfield	**5.3** (1)
Rushcliffe	**5.3** (1)
Housing Status	
Rough Sleeping	**5.3** (1)
Supported Housing	**89.5** (17)
Council Tenancy	**5.3** (1)
Work status	
Not doing any work or training	**100** (19)
	Mean (SD)
Age (years)	**26.1** (10.0)
Male	**27.0** (11.7)
Female	**25.0** (8.2)
Time in current housing situation (months)	**7.5** (7.9)
Male	**7.1** (6.3)
Female	**7.9** (7.9)

N.B: All participants: White British, never been in the armed services, did not identify as transgender, UK National.

2.5. Data Analysis

The focus groups and interviews were audio-recorded and transcribed verbatim. We used thematic analysis to assess the total data set gathered from both the focus group and individual interviews (staff and service users) together. This approach is suited to questions relating to people's experiences and to the ways in which people construct meaning from their experiences. Its purpose is to identify patterns of meaning across a data set. We used the six steps advised by Braun and Clarke (2006), which include first becoming familiar with the data set, then identifying initial codes, searching for themes which emerge, reviewing those themes, and then settling on the final themes before writing up. To ensure the credibility and reliability of coding, transcriptions were independently reviewed and coded by all members of the team and discrepancies and key themes were discussed. To ensure a degree of reflexivity, the researchers discussed pre-existing knowledge, perceptions, and biases in relation to the subject before assessing the data.

All analyses of quantitative questionnaire data were carried out using Statistical Package for the Social Sciences (SPSS) 26.0. Standard descriptive statistics were produced in order to characterize the sample.

2.6. COVID-19 Impact on the Research

All parties were keen that rough sleepers would be spoken to directly as part of the evaluation, and initial plans were made for the research team to visit Nottinghamshire for this purpose. Because of ongoing restrictions and concerns, it was not possible to do this in a way that would not increase risk. We were able to speak to several service users via telephone or video link and whilst the numbers were less than initially anticipated we were able to gather some in depth account from service users to inform and complement the views of staff.

COVID-19 has clearly impacted on services in significant ways, though not always as anticipated. This is discussed in the findings below.

3. Findings and Recommendations

In the main body of the report that follows, the results from our findings are combined with discussion and references to relevant literature. This should also be read alongside the separate and more comprehensive literature review.

The first point to highlight is that the programmes are achieving the key aim of reducing the number of rough sleepers in the county. The regular data collected for monitoring purposes is indicative of decreased numbers of rough sleepers, resulting from RSI and RRP support.

Recent data from routine monitoring reports suggest that these numbers have reduced steadily as projects have developed.

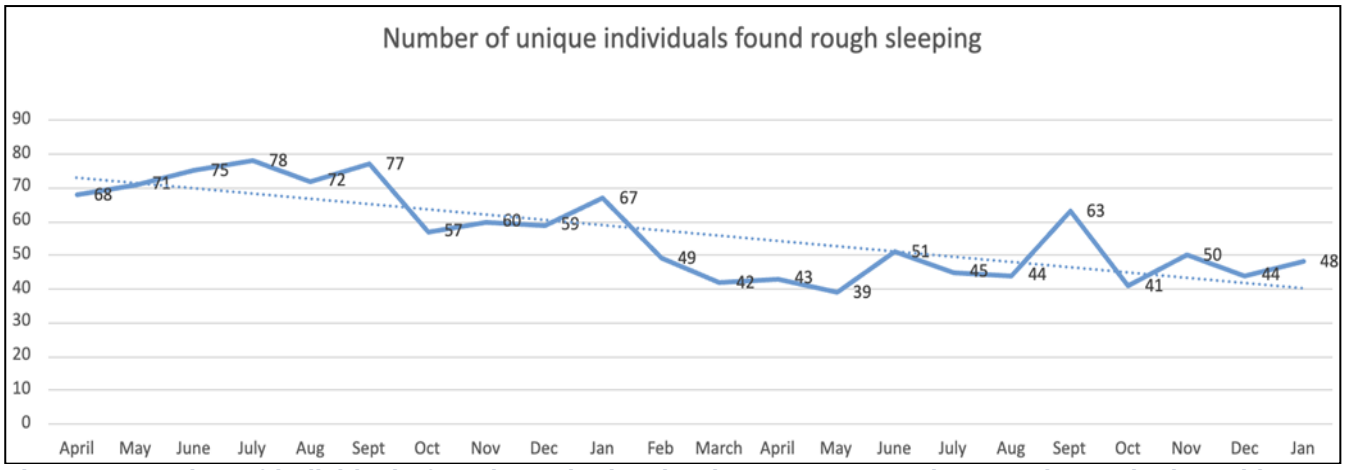


Figure 2: Number of individuals found rough sleeping by street outreach teams in Nottinghamshire April 2019 - January 2021. Source: RSI and RRP routine data monitoring.

The above finding was confirmed by many of the staff that we spoke to:

RSI....it does what it says on the tin really. Yeah, I think it's been successful because I think it's helped accommodate lots of people; and those people may not have survived if they hadn't had access to that. So, for me that's success, and I kind of look at things like that; very logical – It's being successful because it's housed rough sleepers, it's done what it's supposed to do. So yes, I think it's been really successful (Staff).

As Table 2 below illustrates, service users who responded to our survey generally agreed that getting support in relation to housing was easy. Perceptions of the ease of access to support in other areas was mixed, and these areas are analysed in more detail further on in the report. The table is also in graph form in the Appendix 2 for ease of viewing the data.

Statement	***Female %***	***Male %***	***Total %***
It is easy to find where to get help with things	12.5	27.3	21.1
When I need help, I usually get it	25.0	0	10.5
Getting support with housing is easy	75.0	63.6	68.4
Getting support for mental health is easy	62.5	63.6	63.2
Getting help for physical health is easy	25.0	18.2	21.1
Getting my medication is easy	12.5	27.3	21.1
I can see my GP if I need to	25.0	36.4	31.6
I can see a mental health worker if I need to	0	36.4	21.1
Getting help for drug use is easy	12.5	27.3	21.1
Getting help for alcohol use is easy	12.5	36.4	26.3
Getting help to stop smoking is easy	12.5	27.3	21.1
Getting help to stop gambling is easy	12.5	27.3	21.1
Getting help with benefits or finances is easy	12.5	36.4	26.3
Getting help to get work or training is easy	25.0	27.3	26.3
Getting help for family issues is easy	25.0	54.5	42.1
If I am feeling isolated or lonely, I know where I can get help	25.0	36.4	31.6
If I was a victim of crime, I would feel happy to report it to the police	28.6	36.4	33.3

Table 2: Service user views on accessing support.

An overall sense of how well the project is working, and the challenges which remain can be gleaned from the free text responses to our survey outlined in Table 3 below.

What is going well:	
It's warm, safe and I am fed	*Not been on the streets, receiving support I need*
At home studying	*Getting the support I need*
Got a roof over my head	*Everything is going well and smoothly*
Keeping up with rent	*Studying*
Having a clean place to live	*Have a place to stay*
Not out of my head	*Nothing as yet as I would have somewhere to go*
Studying	*It's nice and quiet*
Nothing	*Everything*
What is not going well:	
It's hard from having own place to being with other people	*Nothing*
Family	*Mental health*
Not sure	*Mental health*
Sharing with others	*Sharing with other users*
Rules	*Part time jobs*
Part time jobs	*Location makes living and access difficult*
Other people not pulling their weight	*Struggling and still homeless*
Everything	
What needs to happen:	
I need to find my own house again	*Nothing*
Moving out	*Management needs to talk to them (others not pulling their weight)*
Own place	*More support mental health ways*
Mixing bubbles	*More support*
Work	*Work*
I need to get my own flat	*Sort me out some housing*
Is there anything else you need to tell us about housing and homelessness?	
It's hard!	*They need more support*
Easier access to housing	*People need more support in finding the right way to go*
I have epilepsy and have depression	*If I could be housed even in a hotel for a few days as that would keep me out of the rain*

Table 3: Overall view of success from service users.

Our own findings and those from regular monitoring support the findings from national data which show that these programmes are successful in terms of reducing rough sleeper numbers. Beyond the headline of rough sleeper numbers, there are a range of other interesting findings which will be useful in planning and shaping future service provision. From the qualitative data, we established 14 themes and 42 sub themes which are summarised in Table 4 below. These are presented in a tabular summary below and then each is elaborated on in turn in the following sections. Where possible we have added quantitative data from responses to our questionnaires, and relevant existing data which we have been provided with. Following each theme, we have attempted to highlight a tripartite summary of key outcomes, critical success factors, and recommendations for the future.

Theme	Sub-theme	Summary
RSI Context	Reasons for homelessness	Differences between staff (finances, behaviour) and SU (relationship breakdown) perceptions.
	Challenges of transitioning from the streets	Trapped due to criminality, right type of accommodation (safety), streets as a way of life, availability of resources from begging.
	Support needs	Complexity, dual diagnosis, trauma, public services resources, criminality, victimisation, feeling unsafe, stigma, lack of police support.
	Variation of activities and outcomes	Diversity of activity and outcomes across RSI network, hard and soft outcomes, practical issues, emotional support and empowerment, unique outcomes. Gap for day centre access for food, warmth and showers.
	RSAG	Differences highlighted across the county by RSAG.
Mental health	Anxiety and/or depression	The most commonly highlighted issues by staff and service users
	Specialist outreach	Outreach from a qualified mental health professional highly valued.
	Specialist services	The need for more rapid access.
Trauma	Victimisation	Causes of trauma. Being a victim of domestic abuse most common.
Substance Use	Alcohol	Most commonly used substance.
	Synthetic cannabinoids	Particular problem in certain towns, which led to new services and ways of working.
	Other substances	Long term heroin use and other examples.
	Housing and substance misuse	No private tenancies offered to drug users.
Complex needs	Dual diagnosis	Highlighted by large no of participants as ongoing problem.
	Barrier to services	Gatekeeping still prevents many individuals accessing either MH or substance use services when they have both issues.
Physical health	Wound care	Success observed by many staff and SU in relation to wound care.
	Respiratory illnesses	Very prevalent. Linked to smoking and poor nutrition.
	Sleep	Highlighted frequently. An unrecognised problem?
Relationships	Multi-agency working	Pooling of skills and knowledge, more opportunities, understanding of bigger picture, partnerships outside of immediate RSI including statutory sector organisations.
	Relationships with SUs	Complexities of building relationships, time, trust empathy, flexibility; joint working facilitates relationship building.
	Family and support networks	Importance of and benefit of linking in with families to offer support.
Accommodation	Intensive support required after accommodation	New set of problems may initially be OK but then transition is difficult, services should not drop off once housed in supported accommodation.
	Barriers and issues relating to private rents	Multiple barriers, private rents not right for many of RSI client group, lack of understanding amongst landlords, not enough properties.
	Pets	The importance of pets to some rough sleepers and the need to not ask them to give them up but creates a barrier to access.
	Shared accommodation	Can work well for some but needs to be carefully considered.
	Accommodation gaps	24 hour supported accommodation, accommodation for higher risk people.

Theme	Sub-theme	Summary
Personal Budgets	Setting up accommodation	Rapid access to funding and flexibility regarding how to use funds.
Landlord support	Engagement and support to landlords	Landlord as client, liaison, building relationships, mediation, reassurances, upstream prevention.
	Funding for private rents	Access to money for rent deposit and rent in advance prevents further hardship, Housing First money to set up a home but a gap outside of Housing First.
RSI and RRP network	SOT alongside CGL	Flexibility, intensity of support, partnership with CGL, building relationships, practical support.
	Navigators	Facilitates partnership working, post accommodation support BUT capacity concerns; some mitigation for this.
	Housing First	Key features intensive support, low case load, long term accommodation, person-centred, access to funding.
	NSNO	Allowed intensive support but limited to new rough sleepers, not entrenched.
Foreign national group	ESOL needs	Some difficulties accessing support for people with ESOL needs.
	Recourse to public funding	Misunderstandings that people not entitled, who in fact are. Significant implications for service access.
	Use of translation services	More accessible translation services required.
Staffing	Experience	Breadth and length of experience including lived experience; need to build on service user involvement/experts by experience.
	Staff training	Need for training for all staff in key issues. Working with trauma. Mental health first aid.
	Staff welfare and support	Need for sound support systems. Buddy systems and supervision. Risk of burnout.
COVID-19 Impact	'Everyone In' Scheme	Government policy to temporarily house all rough sleepers.
	Improved partnerships	Partnership working amongst statutory organisations and voluntary and community sector services.
	Medication and script distribution	Distribution of prescription medication.

Table 4: Themes and Subthemes from Qualitative Analysis.

3.1. Theme: RSI Context

We begin with what we have described as a theme of 'contextual' factors. This includes the reasons given for rough sleeping, from both staff and service user perspectives, and the varying activities and outcomes which are important to consider.

3.1.1. Reasons for homelessness

The reasons for homelessness amongst people accessing RSI services were diverse, and often complex. However, there appeared to be some differences in the perceptions between staff and service users. For example, service users most often reported homelessness due to individual circumstances such family breakdown or issues in the family home, including overcrowding. Relationship breakdown is one of the top reasons for homelessness cited in a recent report by Homeless Link (2021). For some individuals, the issues had been going on a long time, or had started from a young age. For others moving to the streets was related to addiction and/or criminality. According to Homeless Link (2021), other individual factors and experiences that can make people more vulnerable to homelessness include poor physical health, mental health problems, alcohol and drugs issues, bereavement, experience of care, and experience of the criminal justice system, all seen within our sample to some degree.

These reasons were reflected in the quantitative data from the questionnaires given to people supported. See Figure 3 below.

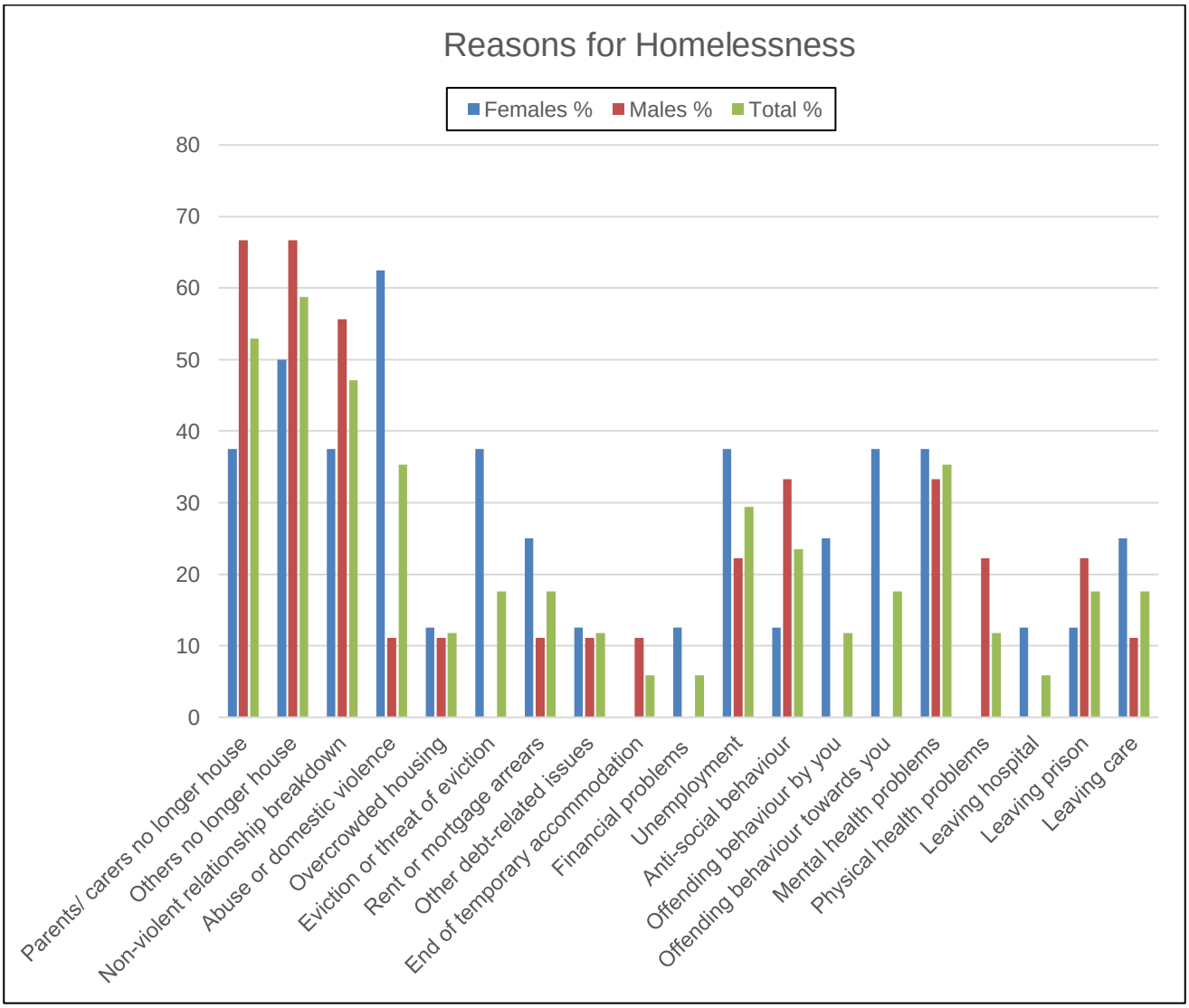


Figure 3: Reasons for Homelessness

However, the perception of staff was different. Staff tended to perceive the reasons for homelessness also to be related to individual (behaviour or family), but also but also wider forces outside of the immediate control of the individual such as finances and rent arrears and noted that this led to many people being found intentionally homeless by the council:

A lot of the time, it is rent arrears, and it's intentional. I've worked with a lot of people who have been intentionally made homeless by the council or going to be. I mean rent arrears doesn't tend to be too much anti-social behaviour, but sometimes that comes a little bit hand in hand; there might be noise complaints regularly and things like that, that has all sort of contributed to the landlord serving notice (Staff).

According to Homeless Link (2021), other structural factors and experiences that can make people more vulnerable to homelessness can include poverty, inequality, housing supply and affordability, unemployment, welfare, and income policies.

Struggling with the challenges of finances and the benefits system was also recognised in our sample. This was also highlighted in the quantitative data from questionnaires with service users and is summarised in Tables 5-7 below:

	Females %	Males %	Total %
Recourse to public funds?	37.5	33.3	35.7
Have you had your benefits sanctioned?	50.0	12.5	31.3
Current main source of income?			
Universal credit	100	80.0	88.2
ESA	0	10.0	5.9
PIP	14.3	0	5.9
Employment	14.3	0	5.9
Friends and family	14.3	0	5.9

Table 5: Income source.

	Females %	Males %	Total %
No debts	50.0	44.4	47.1
Yes I have debt	50.0	55.6	52.9
Yes and I am paying all of them	0	44.4	23.5
Yes and I am paying some of them	50.0	11.1	29.4
	Mean (SD)	**Mean (SD)**	**Mean (SD)**
How much debt?	£2125.0 (1723.1)	£990.0 (1309.3)	£1638.6 (1556.9)

Table 6: Prevalence of debt.

	Females %	Males %	Total %
Rent arrears	50.0	40.0	44.0
Drug debt	50.0	0	22.2
Borrowed from friend or family	50.0	20.0	33.3
Bank loan	0	20.0	11.1
Court fines	50.0	0	22.2
Other loan	60.0	80.0	70.0
Other please state: *Credit card*			

Table 7: Type of debt.

A summary of self-reported previous experiences of homelessness was provided through the data from questionnaires and is shown in Table 8 below.

Event	Female %	Mean age (SD)	Male %	Mean age (SD)	Total %	Mean age (SD)
Slept rough	**75.0**	24.8 (12.7)	**70.0**	18.5 (0.7)	**72.2**	22.7 (10.4)
Lived in a tent	**12.5**	43.0 (0)	**40.0**	21.0 (7.1)	**27.8**	28.3 (13.7)
Sofa surfed	**50.0**	21.7 (14.2)	**60.0**	18.7 (4.5)	**55.6**	20.4 (10.5)
Stayed in a night shelter	**25.0**	43.0 (0)	**20.0**	21.0 (0)	**22.2**	32.0 (15.6)
Applied to the council as homeless	**87.5**	26.5 (11.8)	**90.0**	19.0 (2.6)	**88.9**	23.3 (9.4)
Applied to a hostel as homeless	**62.5**	31.0 (17.0)	**60.0**	21.5 (7.8)	**61.1**	26.3 (12.1)
Stayed in a refuge following domestic violence	**25.0**	38.0 (0)	**10.0**	-	**16.7**	38.0 (0)
Had a council tenancy	**25.0**	18.0 (0)	**40.0**	23.0 (0)	**33.3**	20.5 (3.5)
Lived in supported housing/hostel	**87.5**	26.5 (11.8)	**70.0**	24.5 (3.5)	**77.8**	25.8 (9.3)
Had your own home	**12.5**	19.0 (0)	**30.0**	25.0 (0)	**22.2**	22.0 (4.2)
Lived in care	**37.5**	14.5 (0.7)	**20.0**	4.0 (0)	**27.8**	11.0 (6.1)

Table 8: Experience of Homelessness.

The reasons outlined for homelessness by service users and staff is also reflective of further empirical evidence from the literature. For example, Barile et al (2018) outlined physical health issues, substance use, mental health issues, major life changes, financial crises and employment difficulties as vulnerabilities and significant events contributing to homelessness. In addition, chronically homeless adults are more likely to have a history of incarceration (Cox et al, 2020).

3.1.2. The challenges of transitioning from living on streets

In addition to the complexities around reasons for people becoming homeless, there was also a prevalent theme around the difficulties of moving from street homelessness. Whilst some of this was related to the need for the right type of accommodation (see also a later section on accommodation), there was recognition from staff that involvement in criminality mean that some people felt trapped on the streets:

We started uncovering all sorts of issues like they were attached to organised crime, in some respects, in terms of drug dealing, or funding their habits ... they were running for other people, so they were kind of attached financially. We were wondering why people weren't … especially when colder weather snaps were coming in, and we started engaging with people, we started moving a couple off the street, we were wondering why other people weren't coming forward for the support that was on offer; and mainly it was to do with not getting the right accommodation, but they are also trapped in a lot of respects (Staff).

However, for some people, the challenges of transitioning from the streets were perceived to be related to their sense of identity; homelessness and/or addiction had become their life, and they felt it was where they belonged. On occasion, this also linked to mental health issues such as personality disorder. Furthermore, staff observed that the transition was difficult due to reasons such as a parallel transition from using drugs and due to changes in the physical environment:

…if they've been out on the streets for a long time they can just struggle to adapt to being inside, and they might not be evicted or anything, but they might decide to give their keys back because they have found it difficult (Staff).

Sometimes the transition was gradual and required negotiation with housing providers to ensure the accommodation was not closed off. Some individuals may be reluctant to move from the streets because the accommodation feels unsuitable, or people feel unsafe.

The reluctance may also be due to the increased availability of some resources on the streets. There is little evidence in the literature on the challenges relating to the transition from homelessness. However, limited evidence suggests that boredom and a lack of meaningful activity may negatively impact mental health in people who had previously experienced homelessness (Marshall et al, 2020).

3.1.3. Support needs

The support needs of people living on the streets and accessing RSI services are complex and diverse. This was highlighted within the current data and within our literature review. The presence of complex needs can mean increased use of emergency public services. For example:

…they worked out there was probably 10 to 15 rough sleepers that were coming through criminal justice system, kind of repeat admissions to the local A&E; there was an ambulance service coming on a regular basis, picking people up (Staff).

This was thought to be predominantly linked to New Psychoactive Substances (NPS) use which are known to lead to increased presentations to emergency services (Tracy et al, 2017). In addition, while homelessness was perceived as a primary need, many people accessing services experience multiple and complex needs in relation to trauma, mental health and drug and alcohol use, and there was a recognition that drug use and mental health were frequently interlinked. There were also histories of criminality for many of the people being supported, and with this came complexities around behaviour orders, registration requirements and risk.

Involvement in the criminal justice system was further highlighted within the self-report questionnaires as summarised in Table 9 below:

	Females %	Males %	Total %
I have committed a crime	16.7	44.4	33.3
I have been arrested	66.7	33.3	46.7
I have been to court	50.0	33.3	40.0
I have been in prison	16.7	11.1	13.3
I have been on probation	33.3	11.1	20.0
I have been given a court fine	50.0	11.1	26.7
I have breached a probation licence	16.7	11.1	13.3

Table 9: Involvement in the criminal justice system.

However, there was also widespread recognition that many people who were being supported had not committed crime, despite adversity and addiction, and/or been victims of serious violent crime. Alongside this, service users also reported issues around stigma, isolation, and pervasive fear. In relation to the issues of fear and crime, some people suggested that there would be greater support from the police.

I think they should just open their eyes a bit and check on the homeless; even if it's just going up to them and saying, 'Are you alright?' You don't get nothing like that, I think they ought to open their eyes a bit. They've got all these PCSO's, but they never check on their homeless (SU).

When people were on the streets, even when supported, there appeared to be issues around access to basic provisions such as food and washing facilities and there were suggestions that this could be improved:

Elevated levels of victimisation amongst homeless communities have been evidenced in the international literature (e.g., Heerde et al, 2020). Victimisation has been shown to exacerbate existing health problems, increase the risks of mental illness and being a perpetrator of violence, reduces quality of life, and is costly to healthcare and social services (Nilsson et al., 2020). This topic area is discussed in further detail below.

3.1.4. Variation of outcomes and activities

The network of services delivered across RSI meant that activities undertaken, and outcomes achieved were hugely varied. It was noted that many of the outcomes were more traditional hard outcomes such as gaining or maintaining accommodation, and dealing with practical issues such as appointments, benefits, and bills. Other outcomes were soft outcomes such as increased independence and empowerment, which cannot necessarily be easily quantified. It was also noted that the intensity of support, even within services varied. Finally, it was noted that safeguarding activity was also present across services and could take up large parts of the working day.

Some outcomes were extremely specific to a person's individual circumstances and could relate to reduced criminal justice contact. For example, the achievements made by someone supported by Housing First support meant he had a court case cancelled:

I believe his solicitor rang him before the court appearance, and said that it had been cancelled – Why? Basically, they can see that since you've moved in, you've not been in any problems with the police, no anti-social behaviour… so that was cancelled yesterday; basically they turned around and said to him that he's done really well since he moved into his accommodation - You've not been a problem, so we're not going to charge you with it (Staff).

Finally, there was recognition amongst staff that activities and outcomes changed over time and that service reviews should account for this.

3.1.5. Rough Sleeper Action Groups (RSAG)

There is a coordination group for the whole county and a coordinator who oversees all services, trying to understand needs and demands and lead on planning. In addition, each local authority in the county convenes a regular Rough Sleeper Action Group that is attended by multiple agencies to share intelligence on cases and agree a joint action plan of support for rough sleepers. These are attended by many of the partners listed above, as well as DWP, Probation, Adult Social Care, Police, and Bassetlaw, Mid-Nottinghamshire, and Greater Nottingham CCGs. As with any such forum, which requires representation from multiple agencies, and deals with complex issues, not every part of every meeting is of value to every agency. However, the RSAGs are highly valued by most participants that we spoke to:

We have homeless networking meetings, with other services, that link into RSI; those have been really useful, we have one once a month, and that's when we just get to share information, and I think one of the guys ND, he attends that meeting as well. I always find these meetings really useful just for sharing information about clients and best practise. I think that works really well. If there are things going on that I don't know about I think that's really important (Staff).

We did hear from two individuals that actions agreed at RSAGs were not always followed-up and one participant suggested that there needed to be a more robust mechanism for ensuring that individuals and agencies were held to account regarding actions that they had agreed to take.

A more co-ordinated approach to tackling rough sleeping is reflective of good practice guidelines outlined in the literature (e.g., Kings Fund, 2020).

Theme 1: RSI and RRP Context **Key Outcomes:** • Outcomes achieved were diverse and varied and included hard and soft outcomes, and individual level outcomes. • Regular RSAG meetings in each district, with attendance from key agencies.
Critical Success Factors: • Recognition of and ability to respond to complex needs, underlying reasons for homelessness, victimisation and criminality. • Information sharing with and from a wide group of relevant agencies via RSAG. Regular attendance from all invited agencies.
Recommendations: • There should be clear understanding amongst staff about the reasons for homelessness so that both pre-disposing (underlying) and perpetuating (trigger) issues may be addressed where appropriate. • Staff, Commissioners, and partner agencies should continue to recognise the challenges of transitioning from the streets to accommodation to be able to support people to feel that accommodation is more appealing and safer than remaining on the streets. • Strategic partners should work to increase awareness and engagement from the police. A neighbouring force has set up a task force specifically to support and engage with rough sleepers. Whilst there has not yet been evaluation of this service, it seems, anecdotally, to have been received positively by the homeless community and the non-homeless local community, as well as partner agencies. • Whilst it is recognised this may be available in some areas of the county, the provision of basic day facilities to access breakfast, warmth and washing facilities should be available in all areas. • Completion of agreed actions should be checked at the beginning of each RSAG meeting. Develop mechanisms for ensuring actions are followed up.

3.2. Theme: Mental Health

The importance of support and interventions in relation to the mental health of service users was one of the most frequent themes highlighted by participants. Such a finding is consistent with previous findings. Reserahc investigating the prevalence of psychological disorders among homeless adults has consistently found that many homeless people experience at least one psychological disorder (e.g. Buhrich, Hodder, & Teesson, 2000), whilst the prevalence of serious mental illness (e.g., major depression, schizophrenia, and bipolar disorder) is reported as high as 30% (Perry & Craig, 2015) and homelessness is also associated with higher rates of personality disorder, self-harm, and attempted suicide (Rees, 2009). Homelessness can be both a cause and a consequence of mental illness and is more likely in individuals multiple needs; a previous analysis of the homeless population in Nottingham found that they were 11 times more likely to have a mental health diagnosis if they had spent time in prison, six times more likely to have a mental health diagnosis if they had physical health issues; and six times more likely to have a mental health diagnosis if they had experienced domestic violence (Reeve et al., 2018). The prevalence of self-reported mental health conditions is highlighted in Figure 4 below.

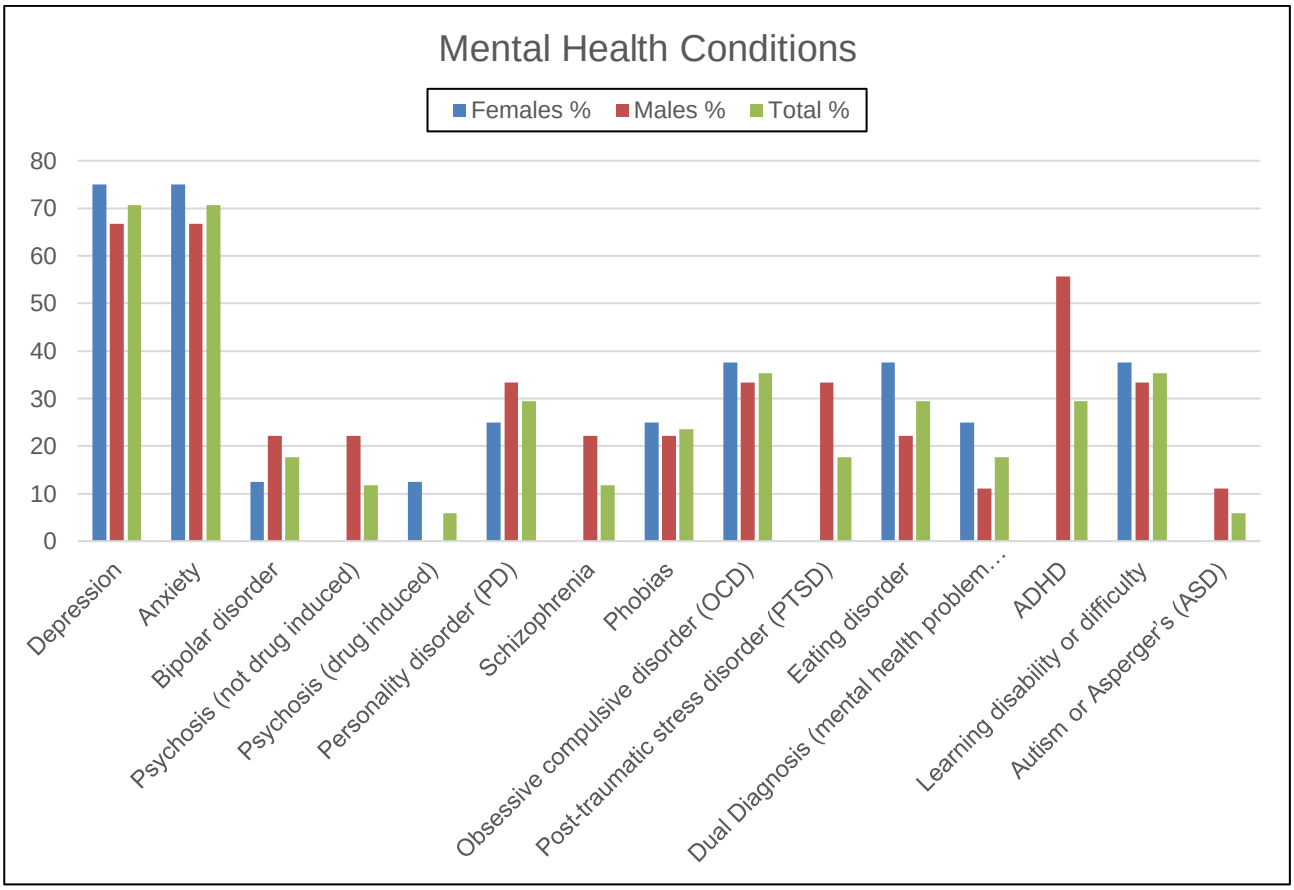


Figure 4: Range of Mental Health Conditions reported in our sample.

3.2.1. Anxiety and/or depression

Responses to our survey indicate an extremely high prevalence of mental health issues, with 83% of our sample reporting moderate or severe anxiety or depression. This is shown in Table 10 below.

		Females %	Males %	Total %
Anxiety/ depression	I am not anxious or depressed	16.7	20.0	18.8
	I am moderately anxious or depressed	50.0	40.0	43.8
	I am extremely anxious or depressed	33.3	40.0	37.5

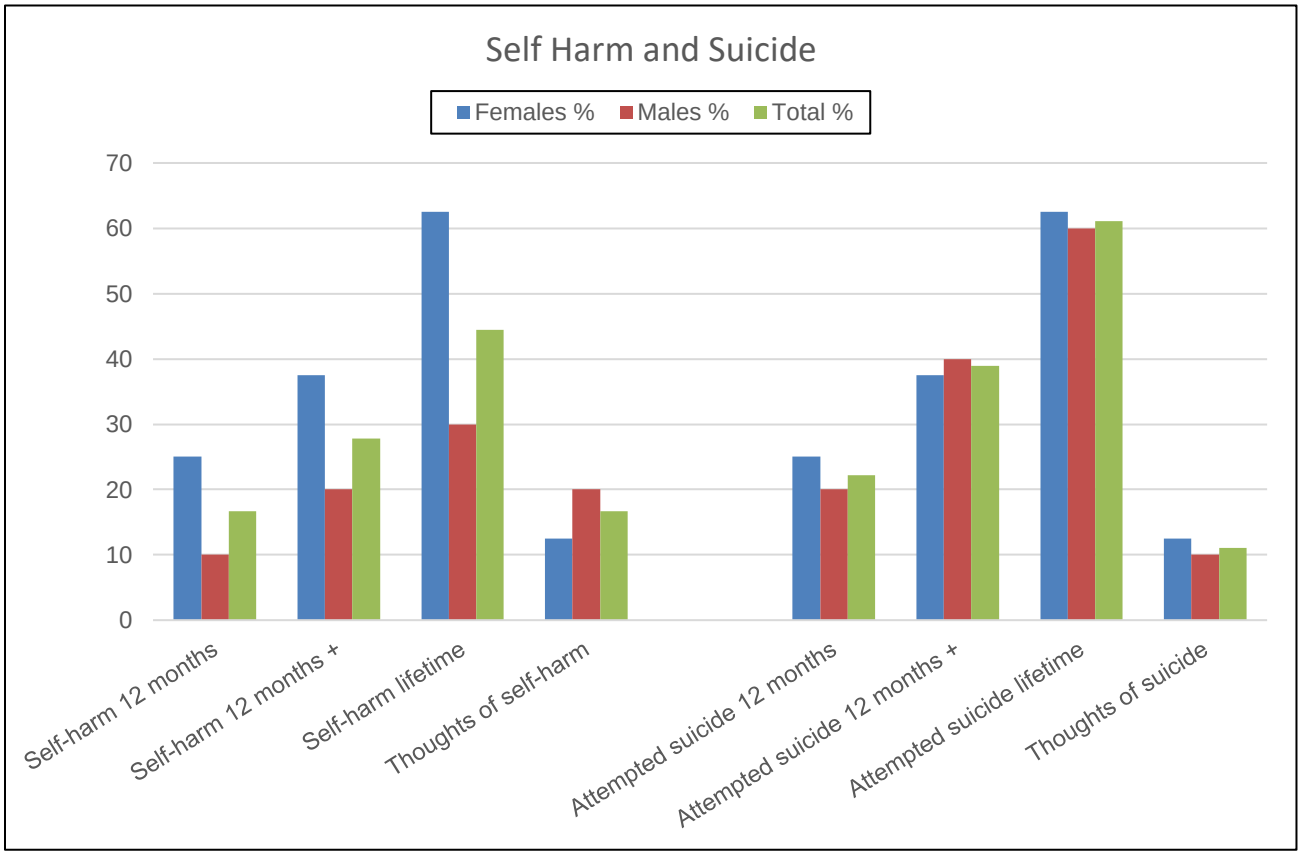
Table 10: Prevalence of anxiety and depression.

This finding is consistent with the literature and depression rates are shown to be over 10 times higher in the homeless population than the general population (Mental Health Foundation, 2015). Many rough sleepers have serious and long-standing mental health problems, and many remain undiagnosed (Perry & Craig, 2015). For a third of respondents to our survey, mental health problems were given as the reason for being homeless, as outlined in Table 11 below.

	Females %		Males %		Total %	
	Most recent	**Lifetime**	**Most recent**	**Lifetime**	**Most recent**	**Lifetime**
Mental health problems	12.5	37.5	30.0	30.0	22.2	33.3

Table 11: Mental health as a reason for homelessness.

Moreover, a substantial proportion of the population have self-harmed or attempted suicide as shown in Figure 5. As noted above, the prevalence of suicidal ideation and suicide attempts among the homeless is



significantly higher than the general population. A previous study found suicide rates to be at least 10 times higher for a homeless cohort (Patterson & Holden, 2012), and other research has indicated a higher suicide rate among people experiencing homelessness than the general population (Bommersbach et al., 2020). Moreover, it has been shown that more than half of people experiencing homelessness have had thoughts of suicide or have attempted suicide (Coohey et al., 2015).

Figure 5: Self harm and suicide reported in our sample.

3.2.2. Specialist outreach

Street outreach is a well-established way of making contact with and getting support for rough sleepers. The literature review highlights the national and international literature which confirms the benefits of this approach (Mackie et al, 2017; Sheikh & Teeman, 2018; Seria Walker et al, 2018). A relatively new development is having trained mental health professionals as part of the street outreach provision. Having a specialist CPN within the team who can also provide continuity of support after individuals are accommodated seems to be a successful model.

Yeah, she's made a massive change to service users with mental health, that wouldn't engage with us on the street, wouldn't go to hospital, wouldn't let you call the crisis team; she's gone out there and offered that support on the street. They've started engaging. A lot of them have moved off the streets. The CPN will carry on supporting them while they were in their accommodations as well. Made a massive difference (Staff).

At the time of the research, there was only one CPN and this meant that this kind of support across the whole county was patchy.

Those sorts of things, even really the rough sleeper CPN, which I think is a great thing, what I would say is that we haven't had a chance to utilise them on any Broxtowe cases. It might be that certain services that fall under the RSI are utilised more by other local authorities. maybe more in the North rather than the South of the borough (Staff).

The message from several participants was that an increase in this kind of provision would pay dividends. Several similar initiatives were funded by the NHS two years ago (NHS, 2019), and several studies have pointed to the importance and benefits of providing specialist mental health care in these settings (Timms and Drife, 2020).

3.2.3. Specialist mental health services

As discussed in the literature review, there is good evidence that intensive support which addresses mental health needs at the same time as housing needs, leads to good outcomes (Mackie et al, 2017). What was often referred to as 'wrap around support,' in which the housing provision is complemented by support in relation to other personal problems, such as mental health problems, was valued by many. Specialist outreach is clearly working well and needs to be complemented by ongoing specialist mental health support.

To successfully house a person, and for that person to maintain a stable housing situation, support in relation to mental health can often be crucial. It was suggested that mental health problems may be 'put to the side' when people were on the streets but must be addressed in order for individuals to be successful with a tenancy. A theme that is echoed in several different sections of this report is the importance of integrating things and also providing longer term support to ensure the best chance of success. The specialist knowledge of working with homeless individuals needs to be complemented by the specialist knowledge of mental health professionals to best support people. Where services do integrate or collaborate well together this is recognised and the benefits are obvious to stakeholders. The level of mental health problems among service users is illustrated by comments to researchers from the small number of service users that we were able to interview:

*D knows I'm upset, But nobody knows I'm this upset and I don't know why I'm telling you, a total stranger; but they don't know it's this bad, no. I'm so depressed I've tried to kill myself so many times over the last few months. It never works. I don't ******* know why. I've literally put so many drugs on a spoon and injected myself. I've taken tablets before and waited for them to kick in. and I just ******* wake up the next day and think what the **** (SU).*

Another critical success factor in relation to mental health relates to information sharing and preventing homelessness for those discharged from residence in a mental health setting. The role of the mental health hospital navigator is crucial in relation to this. This emerged from our data and also in recent reviews of evidence (Waid et al, 2021).

The need for mental health support for a considerable proportion of the service users, and the complexity of needs and services, has led to calls for the involvement of those with more decision-making responsibility from mental health service providers. Discussions at the steering group indicate that the presence of a more senior representative from the Mental Health Trust would aid processes and the provision of appropriate services.

Theme 2: Mental Health **Key Outcomes:** • Identify and support those at risk of rough sleeping due to mental health issues
Critical Success Factors: • Providing rapid and effective access to mental health support through assertive outreach • Information sharing. • The role of the navigators. • Rapid access to specialist mental health services.
Recommendations: • Prioritise having more street outreach from mental health professionals, to cover the whole county. • Ensure senior level representation from mental health providers at county RSI steering group.

3.3 Theme: Trauma

There has been a growing body of evidence in recent years that single or multiple traumas of some kind play a part in the origin of a significant number of cases of diagnosed mental disorders. For example, the prevalence of violence in the family home when growing up (38%) or experience of sexual abuse (34%) are remarkably high in those who develop psychosis (Bebbington et al., 2014). This is also the case in relation to substance misuse. Up to 59% of young people with PTSD subsequently develop substance abuse problems. This seems to be an especially strong relationship in girls (Lipschitz et al, 2003). The issue was touched on above when discussing those two issues, and several respondents highlighted trauma as a significant issue:

But for them, anecdotally I get feedback, and I think there is about 80 cases that we have worked with in total, maybe even more, and everybody is different, but anecdotally, as a collective, I pick up the people, the trauma is there, and years of drug use has been their coping mechanisms for reality (Staff).

Homeless individuals often report traumatic personal histories (Spence et al., 2006) and elevated levels of adverse childhood events (Spence et al., 2009). A previous study looked at the relationship between adverse childhood experiences and homelessness and the impact of mental health problems. Findings revealed that childhood adversities are found to be significantly prevalent in homeless samples and a history of such adversity is related to poor outcomes (Roos et al., 2013). Common pathways into homelessness can also include financial debts and domestic conflicts (van Laere et al., 2009). Given that single or more commonly complex and multiple traumas are in the background for many rough sleepers (Maguire et al, 2009) and that the experience of rough sleeping often exposes people to further trauma, it is clear that this is a key issue which will need to be addressed in order for individuals to achieve successful outcomes.

The literature review discussed how awareness of the impact of trauma is filtering into work with rough sleepers, and the concepts of psychologically informed environments (PIE), and trauma-informed support are gaining traction. Seria Walker, in her review for Public Health England listed PIE as a promising evidence based intervention(Seria Walker, 2018).Training for frontline staff in terms of recognising and sensitivity on their part in responding to the issues is necessary. Often, more intensive work may be required, which may be best done via specialist mental health services (Kings Fund, 2020).

3.3.1 Victimisation

Trauma can be the result of a range of life experiences, and often follows from an experience of being the victim of crime or abuse of some kind. Research has shown that victimisation is high in homelessness populations (Choe, Teplin, & Abram, 2008). The prevalence of physical or sexual assault victimisation within the past year has been estimated to range from 27% to 52% in homeless populations (Fazel, Geddes, & Kushel, 2014). Moreover, homeless individuals have complex health problems, including psychiatric disorders, and both substance use disorders and mental illnesses are linked to increased risk of victimisation (Sariaslan et al., 2020). As Table 12 below illustrates, the most common cause in our sample was domestic abuse, with high levels also of experience of theft, bullying and sexual crimes.

Experience	Females %	Males %	Total %
I have been a victim of a non-violent or non-sexual crime (e.g., theft)	42.9	0	25.0
I have been a victim of a violent but non-sexual crime	28.6	16.7	23.1
I have been the victim of a sexual crime	42.9	33.3	38.5
I have been the victim of bullying	42.9	40.0	41.7
I have been a victim of trafficking	0	0	0
I have been a victim of cuckooing	0	0	0
I have been a victim of slavery	0	0	0
I have been a victim of domestic abuse	71.4	0	41.7
I have been a victim of a different type of crime (Please state): Unlawfully evicted	14.3	0	8.3
I have reported a crime to the police	33.3	16.7	25.0
I have received health treatment following a crime	33.3	16.7	25.0
Other experience of crime (please state): Hate Crime	12.5	0	5.6

Table 12: Summary of some of the types of trauma and victimisation in our sample.

Theme 3: Trauma **Key Outcomes:** • Referrals to specialist mental health support in relation to histories of trauma and victimisation.
Critical Success Factors: • Awareness of the existence and impact of trauma on individuals. • Referrals to appropriate specialist support.
Recommendation: • Development of a comprehensive training plan to ensure that all staff can access relevant training on trauma informed interventions and adopt a trauma-informed approach within their practice.

3.4. Theme: Substance Use

Next to mental health, the importance of support and interventions in relation to alcohol or other substance use was the next most frequent theme highlighted by participants, both staff and service users. The physical and mental health of rough sleepers is often impacted by long term substance use. Issues relating to substance use may be one of the causes of homelessness for some but once on the streets, substance use becomes a coping strategy for many more. There is evidence that suggests a strong reciprocal association between being homeless and having an increased risk of problematic alcohol or other drug use (ACMD, 2019). A meta-analysis has shown that drug dependence can range from 4.5 to 54.2% among homeless populations (Fazel et al., 2009). The self-reported prevalence of drug use is highlighted below in Figure 6.

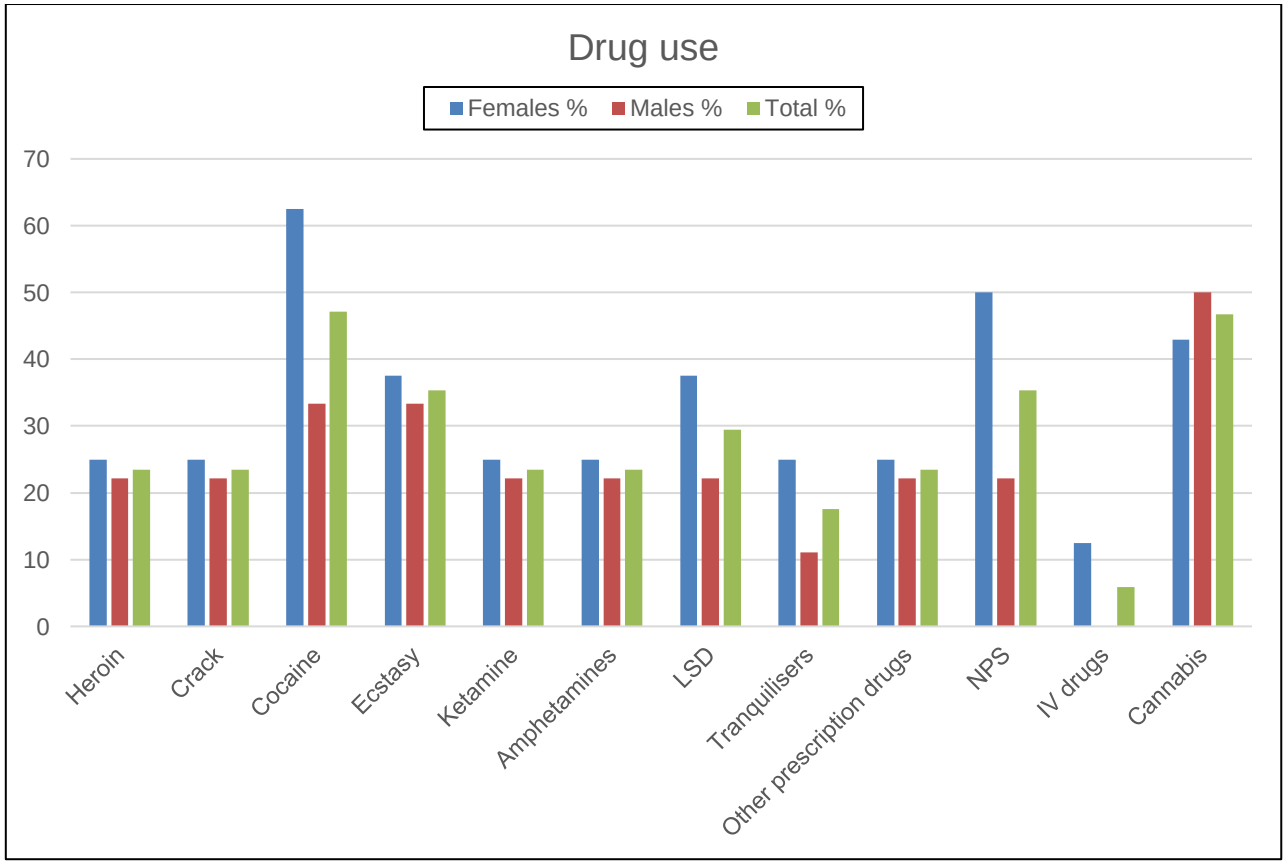


Figure 6: Types of drug use reported in our sample.

As highlighted above, substance use plays a key role in the lives of rough sleepers. The use may pre-date the rough sleeping or be a response to the harshness of sleeping on the streets. The critical point in terms of successful outcomes is getting specialist support for people. Again, the street outreach approach was highlighted as especially useful as an approach leading to successful outcomes.This service is supported by medical practitioners who can offer substitute prescribing for drug users.

As with the discussion above about mental health, what enables successful outcomes for rough sleepers who present with substance abuse problems is an integrated approach to working with the range of personal presenting issues. Several of the housing-based services expressed a desire to have more specialist substance use support directly located within their own service:

I mean, we work with CGL, and they do a fantastic job, but we would like to have somebody either hot desking in our office, having that more working relationship with our team, because we don't have that speciality within our team. We do have a counsellor in the Mansfield, and she's linked to the multicomplex needs; therapy informed counsellor; something like that, But she works really well, and she works with a multi complex needs high risk ones; she's linked to that project but ideally, we'd like to have a linked drug worker as well (Staff).

Specialist support provided via outreach works very well for many. The organisation which provides this support for RSI project users also offers a comprehensive substance misuse treatment and recovery service in the county, with no age limits, which includes specialist teams, covering family support, hospital liaison and specialist teams supporting those with alcohol dependence and other drug dependencies. Beyond this, there can be a need for more intensive and long-term specialist support. As discussed in the literature review there are a range of views and findings about the place of residential rehabilitation for individuals with entrenched substance use related problems. The housing first approach was developed specifically to provide housing alongside support for substance related problems in a coordinated package (Watson et al, 2017).A review of therapeutic community literature concluded that significantly greater reductions in substance use have been found for homeless people with co-occurring substance misuse problems treated in therapeutic community programmes than for those in treatment as customarily provided by homeless and housing services (Mackie et al ,2017).Views across our participants and across the county also varied. We were informed that there are clear existing pathways for individuals to access residential rehab and detox. The pathway requires: engagement with services, abstinence, and engagement with local services first (e.g., mental health services).

Providers of substance misuse services suggest that there is little sufficient provision of residential rehab and detoxification for those who require it. They also pointed to a problem in the sector in that a lot of facilities now exist which offer residential treatment for substance use and use housing benefit income to provide limited facilities and support. These are not rehabilitation centres proper and offer little or no psychotherapy or the specialist interventions that individuals may require. Other participants suggested that there does need to be more accessible provision of specialist treatment via rehab and that the criteria for being accepted onto the pathways for rehab are sometimes unrealistic. Specialist organisations suggest that treatment provision for this population needs to be tailored to the needs of the population and include harm reduction, needle exchanges, substitution treatment, peer mentors and other evidence-based approaches as required (ACMD, 2019).

Specialist support can be important, but it is also about persistence and the intensity of support. As shown in the literature review intensive and ongoing support tends to pay dividends. Several of the studies included in the review by Mackie et al (2017) made this point clearly.

COVID-19 and the resulting restrictions on movement had some interesting effects on substance use behaviour. It was reported that some people were trying different substances because they could not get hold of the ones they normally would.

3.4.1. Alcohol

Reflecting widespread availability and use in wider society, alcohol is the most commonly used substance. Homelessness and substance use are intricately related. Estimates of alcohol use among people experiencing homelessness vary depending on the population studied and definitions used but are consistently higher than average (Fischer & Breakey, 1991; O'Toole et al., 2004). A meta-analysis of international studies found alcohol dependence ranging from 8.1 to 58.5% (Fazel et al., 2008).

3.4.2. Synthetic cannabinoids

At times, new problems relating to particular substances emerge and can cause high profile and visible problems, and a range of public, political, and service responses. The emergence of exceedingly high strength cannabinoids led to issues in several UK towns and cities in recent years (Alexandrescu, 2020). Findings suggests that victimization is common among homeless persons who use synthetic cannabinoids. E.g., Spice; Incapacitation often rapidly follows use, which in turn precipitates victimization (Ellsworth, 2019). Some of our respondents talked explicitly about this issue regarding how it had forced them to adopt new ways of working, but also how it acted as an opportunity to raise the profile and importance of substance misuse services.

The self-reported prevalence of problematic drug and alcohol use is summarised in Figure 7 below.

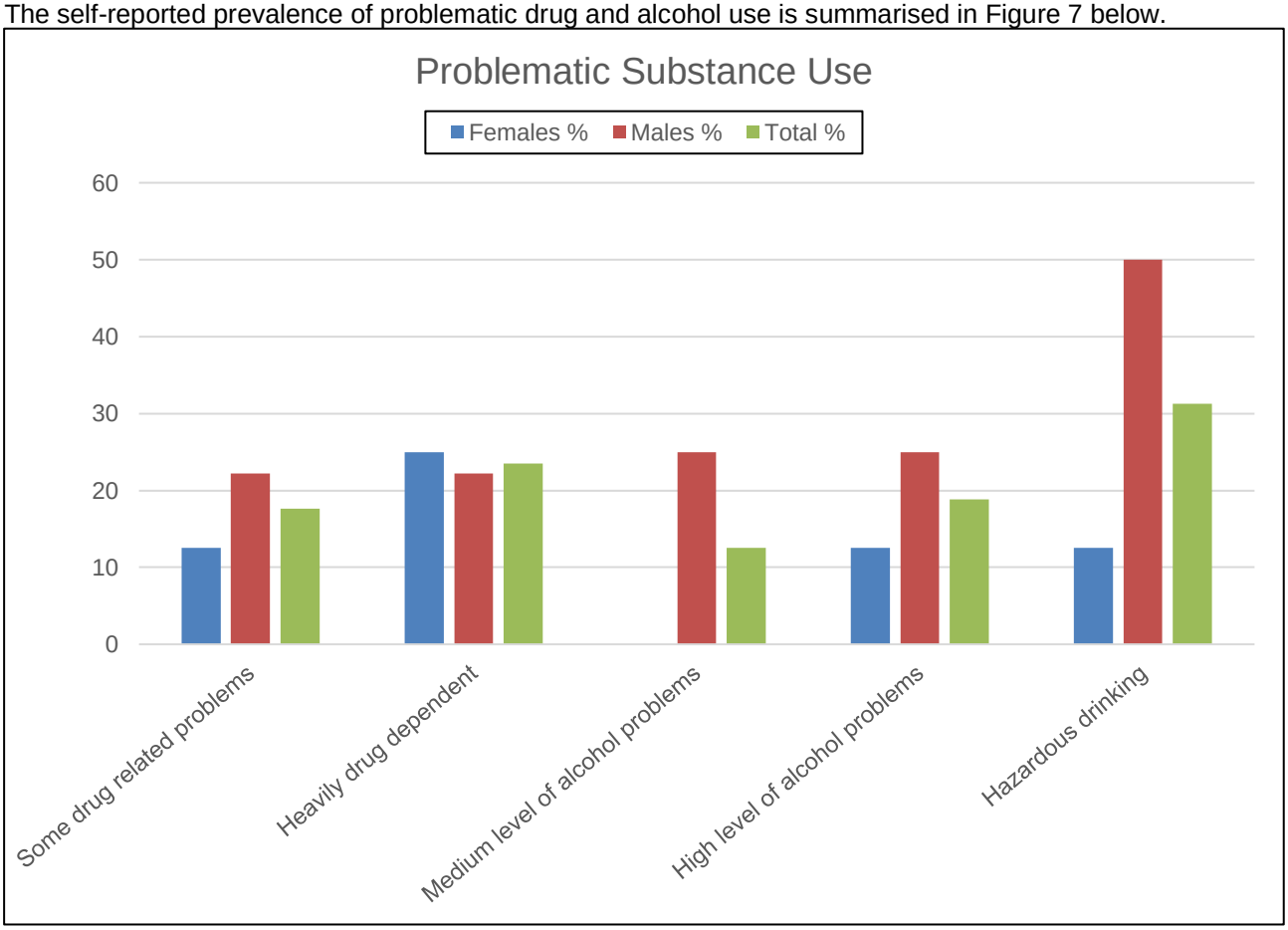


Figure 7: Alcohol problems and other problematic substance use reported in our sample.

3.4.3. Other substances

A range of other substances were mentioned, including heroin and amphetamines. Effects of drug use manifested in a range of ways:

I can't really tell you any positives at the minute; I'm losing my hair due to alopecia stress, and I've got drug induced schizophrenia; But I have been clean now for a year and a half; that's not a problem now but I'm still having to deal with the side effects of taking the drugs earlier on in my life (SU).

3.4.4. Housing and substance misuse

Finally, in relation to substance use, it is clear that the projects have been successful in housing a number of individuals with ongoing substance misuse problems. However, there remain challenges, particular in the domain of private renting. There is agreement in the literature that a Housing First approach (Cherner et al, 2017) or other interventions that offer a stable housing solution alongside substance misuse treatment, are crucial to successful outcomes (ACMD, 2019). This works best when a person centred approach with a harm reduction focus is adopted (Bernad et al, 2018).

Theme 4: Substance Use **Key Outcomes:** • Supporting many individuals to moderate/manage substance misuse alongside housing support.
Critical Success Factors: • Street outreach from specialist substance misuse services. Intensive and ongoing support. Specialist substance misuse treatment where needed.
Recommendations: • Ensure pathways to specialist support/ detox/rehabilitation are available when necessary.

3.5. Theme: Complex Needs

The complexity referred to by this title can refer to a range of diverse needs but often includes mental health and substance use, as well as experience of trauma, experience of being in prison, family breakdown, and a number of others. Complex needs are shown to be as an increasing problem in homeless populations (Adamson et al., 2015). According to Crisis, the more complex needs someone has, the more help they will need to move on from homelessness and rebuild their lives (Crisis, 2021). Complex needs support is offered as part of the current RSI and RRP provision in Nottinghamshire. Those with 'complex needs' may pose the greatest challenges in terms of a service response. They are also the group who may particularly need intense, ongoing, and specialist support if they are to remain successfully housed. We heard that the current provision for complex needs is working well in terms of preventing people rough sleeping, and some staff and service users only offered praise and thanks for the provision. However, one more experienced staff member offered a cautionary note:

Complex needs hostels serve a good function in lots of respects, but they also placing together 15 plus people who all have complex needs, who usually all misuse substances, who may have histories together; you know, sometimes positive histories together may actually encourage continuation of time on the streets; sometimes much less positive histories of kind of interpersonal trauma between each other, and you can't always know when somebody new moves into the hostel, what their relationship with the other 14 might be (Staff).

3.5.1. Dual diagnosis

The label complex needs is often applied when an individual has some combination of mental health and substance use problems. Previous research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in community substance misuse treatment (Delgadillo et al, 2012). A critical success factor in dealing with mental health problems, and substance use related problems, is often the opportunity to deal with both together. The issue of 'dual diagnosis' has been recognised as an important one for several decades and policy and practice initiatives have sought to deal with it. Several iterations of guidance from the National Institute for Clinical Excellence (NICE) have been produced, first in 2002, and most recently in 2016, which provided detailed protocols for services.

Dual diagnosis is very prevalent in the populations that the projects are working with. Literature has suggested that levels of dual diagnosis in this population are up to 69% (Homeless Link, undated). The routine data completed by the CPN employed in the street outreach suggests that *all* her clients had co-morbid substance misuse as well as mental health problems, in each of the last three months of data returns, highlighting just how important the issue is. The NICE guidance provides details on how best to manage referrals, joint working between agencies, care planning, and other matters. However, a review which has just been published (Alsuhaibani et al, 2021), shows clearly that guidelines on mental health, substance use, and dual diagnosis, are deficient. In their words, "the social causes and consequences of dual diagnosis such as homelessness and safeguarding and associated referral pathways were sparsely mentioned"(p1). There is an urgent need for more research and clarity for commissioners and service providers in this area.

However, in an era of austerity many dual diagnosis services were cut back in the last fifteen years (QNI, 2020), and services often do not meet required needs, something which was commented on by a number of our participants. This is a significant issue for commissioning. Public Health England guidance suggests that multi-disciplinary teams should be set up to tackle the issue (PHE, 2017). Others suggest that mental health and substance misuse teams should be co located and that Health and Well Being boards should produce yearly plans and assessments of how well the services are working for users (Turning Point, 2016).

3.5.2. Barriers to services

The barriers to services and the ongoing need for support in this area were highlighted in a number of accounts. Previous literature has shown that repeatedly, individuals experiencing homelessness have complex needs but limited access to services, which directly contributes to high rates of morbidity and mortality (e.g., Addorisio et al., 2021). Where individuals have complex needs, individual services are often reluctant to take on the individual, and staff in some of the projects reported spending a lot of time trying to persuade GPs, mental health services, and substance misuse services to offer appointments to some of the individuals.

It remains the case that some individuals have needs which challenge even the best thought out service and the best models of practice:

That even people that need supported accommodation, there's not any supported accommodation for people with higher needs; they're all too high risk. Even with complex needs projects, they are too complex for a complex needs project; that's a really big gap (Staff).

As noted in the literature review, there are no easy answers to such challenges, and it is sometimes a case of maintaining the offer until it is the right moment for that individual. As noted by Seria Walker (2018) in her review, there is not a great deal of evidence on which to base recommendations for interventions for rough sleepers with the most complex needs. Referral to specialist support for each of the specific needs is warranted as discussed in other sections of this report relating to mental health, substance use etc. Assertive outreach, and ongoing support for the individual also have evidence to recommend them for this population (Seria Walker, 2018).

Theme 5: Complex Needs **Key Outcomes:** • Assessment by specialist CPN on an outreach basis.
Critical Success Factors: • Support for individuals to deal with all issues at once, rather than expecting a sequential resolution of different issues.
Recommendations: • Prioritise the development of specialist dual diagnosis services. Follow NICE and other guidance on standards for dual diagnosis services.

3.6. Theme: Physical health

The physical health of homeless individuals has often been overlooked. Our review of the literature noted the significant mortality gap between rough sleepers and the rest of the population, and pointed to a number of studies which have explored the health problems which contribute to this gap. For example, Aldridge et al (2019) analysed medical records in London and found that homeless individuals were twice as likely to die from strokes as those from a low socio economic group who have a home. A third of deaths in the homeless cohort were due to treatable conditions such as Tuberculosis. Rough sleepers have a wide range of complex and multiple health and care needs which are associated with their housing and other support needs (Lewer et al., 2019a; Wilson & Barton, 2021). Consequently, the mortality rate is high for rough sleepers, with the average age of death 46 years for men and 43 years for women; with the common causes of death being drug-related poisoning, suicide, and alcohol-related causes (ONS, 2020). Information about the physical health of the cohort is also indicated in the data returned via questionnaires. From interviews, the following range of physical health problems were highlighted: alopecia, heart defects, COPD, kidney failure, cancer, broken bones, slipped discs, diabetes, hepatitis C, physical disabilities. Examples of further physical health problems reported in our sample are given in Figure 8 below:

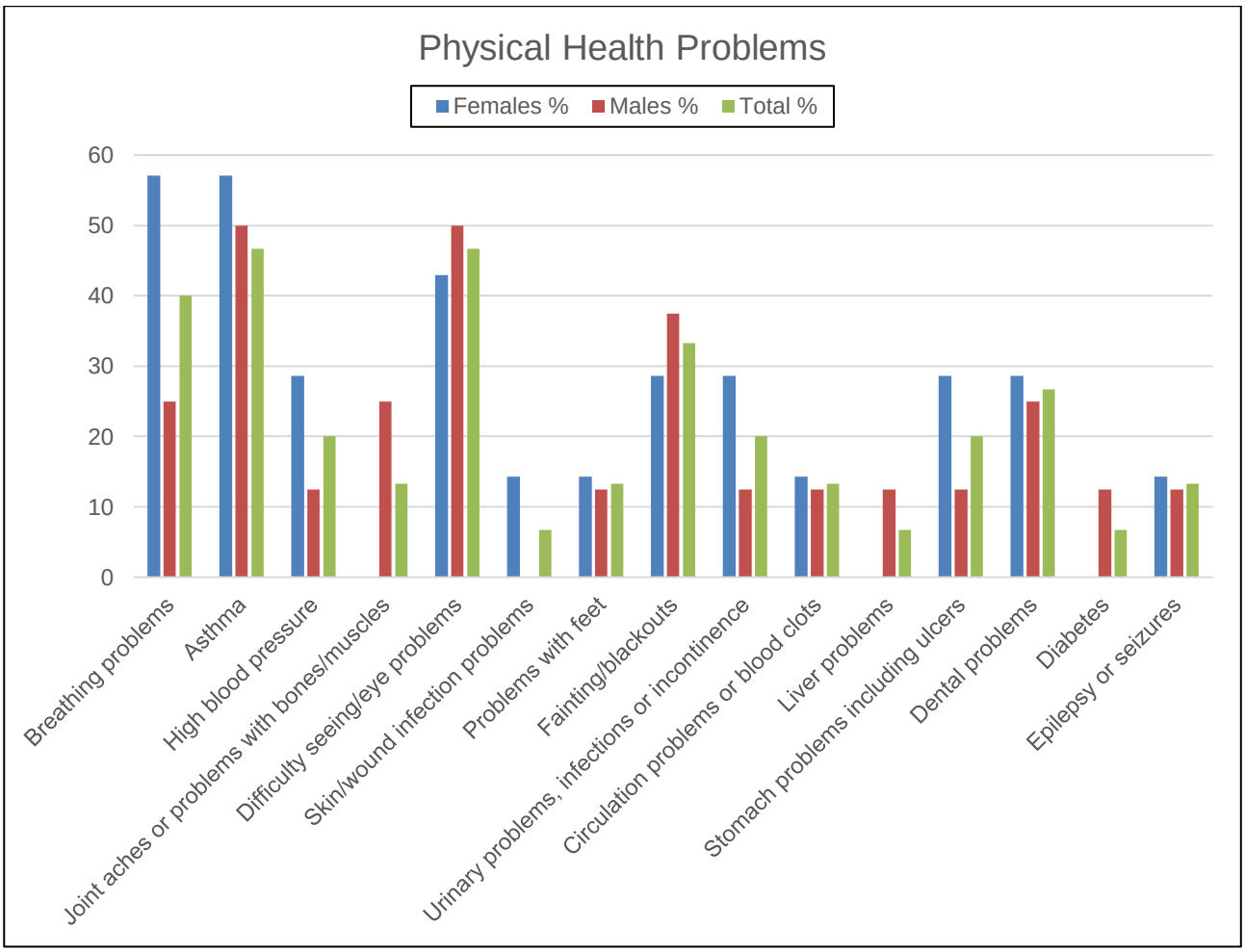


Figure 8: Examples of physical health problems reported in our sample.

Just over 50% of the sample were receiving treatment for their physical illness according to our questionnaire, as reported in Table 13 below.

	Females %	Males %	Total %
Yes, I'm receiving treatment for all	57.1	57.1	57.1
I'm receiving treatment for some but not others	14.3	14.3	14.3
No, but it would help me	0	28.6	14.3
No, I don't need it	14.3	0	7.1
No, I don't want it	14.3	0	7.1

Table 13: Treatment for physical health problems.

It should be noted that the data above reflects a relatively small sample and is not representative of the rough sleeper population as a whole. Whilst high levels of respiratory problems are confirmed, the nurse practitioner referred to high levels of uncontrolled diabetes (whereas only 6% of our sample mentioned diabetes), and wound problems are also only mentioned by 6% of our sample.

3.6.1. Wound care

Needs in relation to wound care had been identified in Nottinghamshire and new tissue viability clinics were set up to meet these needs. We were able to interview the nurse practitioner who set up the clinics and also gathered views on this issue from a range of participants who had witnessed the benefits of this initiative.

I know that S does more of the bandages and wound, that kind of stuff, but actually we've used her where there's been people. They've got physical health needs, and we've said that will go within to the GP, will go with them to the hospital, we will ring this doctor for you; we will basically encourage them and try and do everything we can for them to engage with physical health, and they have just said no they didn't want it; and even as far as calling an ambulance for them, calling a paramedic, calling 111, but they've not wanted to. So, where S has being useful is that she can liaise with GP's. We can tell her things like this person's health is really bad, this person could really do with a prescription, like a food supplement because they're losing weight. You might not necessarily have to see or speak to a professional, if we've got that relationship, it can kind of be done through us; getting medication arranged or getting people to go and do blood tests. So, it's really helpful in that aspect (Staff).

This experience reflects a growing national awareness of the importance of providing wound care in homeless populations (Fedorowicz & Gidlow 2020), something which has been highlighted further during the COVID 19 crisis (Fletcher et al., 2020).

3.6.2. Respiratory problems

The specialist service is clearly working well. The nurse practitioner suggested that, whilst the clinics had been set up with a wound care focus, many of the issues that she picked up related to respiratory illness:

I was brought in to focus on wound care, which is an issue. But I also see a lot of chest problems. A lot of them smoke heavily, have COPD (chronic obstructive pulmonary disease), and don't take their medicines (Staff).

Service users that we were able to speak with also raised similar issues. This was also confirmed by our data sample below (Figure 9) that also shows that almost all of the participants are smokers. The nurse practitioner also noted the extremely poor nutrition of this group, and these factors together make it unsurprising that respiratory problems are widespread. Previous literature has shown that respiratory problems are highly prevalent in homeless populations. One study showed that the most prevalent medical problem was upper respiratory infection (47%), which was exacerbated by the high rate (73%) of smoking found among the sample (Sachs-Ericsson,1999).

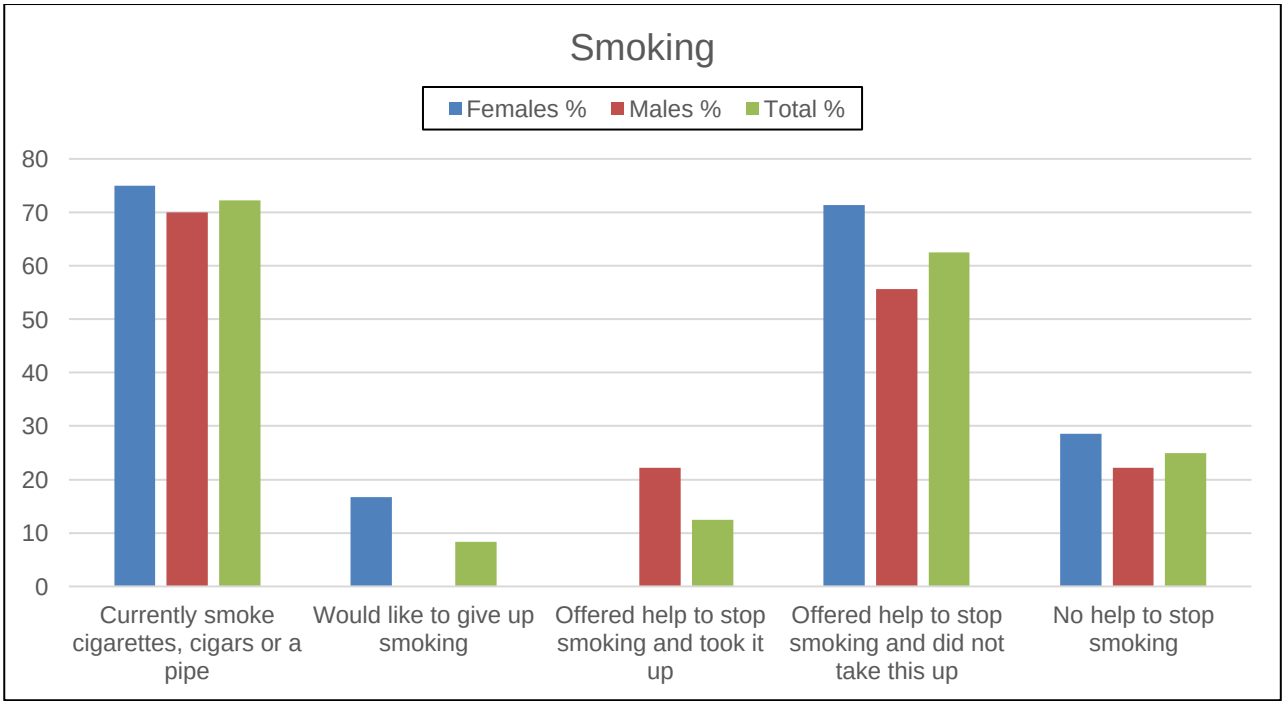


Figure 9: Smoking reported in our sample.

Issues regarding access to primary care were highlighted in the literature review. A recent Kings Fund (2020) publication noted the significant unmet health needs of this population, and how many of these needs could be met by Primary Care. Studies have shown improved health outcomes with better access to primary care (Riley et al, 2013).This remains a problem in most areas, and barriers were highlighted by participants.

We heard examples of quite serious health problems which were not necessarily being monitored/managed:

I have actually got a heart defect. I was in hospital for four weeks a few years back. I was meant to have heart surgery, but luckily, they gave me some kind of medication, so it didn't have to have the operation after all. I was meant to go for checkups twice a year, but I haven't been for a long time. When I got sorted, I was obviously planning to go and get checked out, but that was when the COVID started, and I didn't want to risk going to the hospital (SU).

Moreover, overall self-reported health was quite poor as summarised in Table 14 and Figure 10 below. Homelessness has been shown to be a key driver of poor health (Stafford & Wood, 2017).

	Females %	Males %	Total %
My health is better than it was 12 months ago	12.5	11.1	11.8
My health is about the same as it was 12 months ago	62.5	55.6	58.8
My health is worse than it was 12 months ago	25.0	33.3	29.4
	Mean (SD)	**Mean (SD)**	**Mean (SD)**
Health Score (max 100)	44.5 (27.7)	55.6 (28.1)	50.7 (27.7)

Table 14: Self-reported health

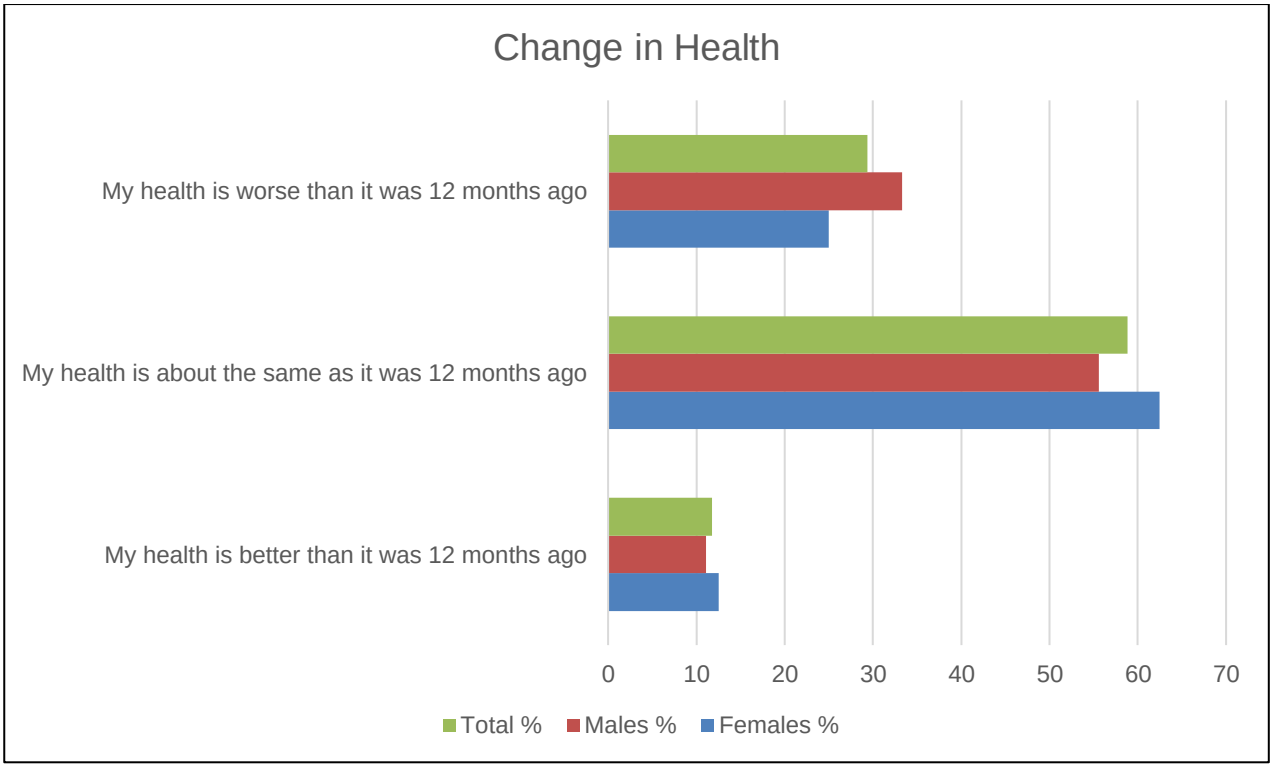


Figure 10: Self-reported health scores in our sample.

3.6.3 Sleep

Difficulties with sleep were identified by a number of participants. This is perhaps unsurprising. It is not an issue that has received a great deal of attention from researchers, but the few published studies concur that sleeping in harsh environmental conditions, particularly cold and damp, and having to be constantly vigilant due to risks of violence and theft, lead to chronic poor sleep (Taylor et al, 2019). Likewise, depression symptoms, severe food insecurity, have also been shown to be significantly associated with increased sleep disturbance in those who are homeless (Redline et al., 2021). Even after being housed, chronic priming of the stress response system may make it difficult to develop good sleep (Moore, 2018). Sleep has been shown to have important implications for the development of chronic diseases such as diabetes, heart disease, obesity, and depression (Centers for Disease Control and Prevention [CDC], 2013).

Overall, our findings echo those in existing literature that a range of sometimes profoundly serious, and often chronic, physical health problems exist in this population.

Theme 6: Physical Health **Key Outcomes:** • Success in dealing with wounds. • Improved foot and leg health.
Critical Success Factors: • Specialist practitioners (e.g., wound care nurse specialist). • Liaison with GPs.
Recommendations: • Add a respiratory specialist to the offer for assertive outreach access for physical health services.

3.7. Theme: Relationships

The importance of relationships was a pervasive theme across the data collected. This was multi-dimensional with a particular focus on the success of a multi-agency response but with also the acknowledgement of the complexities and importance of building relationships with service users, and also of supporting them to build relationships with their families. This is reflective of the importance of cross sector working highlighted within the literature review (Mackie et al, 2017).

3.7.1: Multi-agency working

Multi-agency working is often cited as a critical success factor in homelessness literature (e.g., Kings Fund, 2020). There was widespread recognition that the RSI and RRP network facilitated the joint working across agencies.

The joint working was viewed very positively and was not seen to be the norm:

I'm really surprised. From previous services that I've worked in, the joint working was hit and miss; it depends on if you found a good worker, social worker or mental health worker, that you'd have that connection with. However, in Mansfield, it is brilliant, the rough sleeper group has all of those agencies on it. I've never seen such committed joint working within any city; at Mansfield I've got no complaints, they work really well together, and I pulled it in that we all work well with that individual (Staff).

However, this multi-agency working extended outside of the immediate RSI services and also incorporated statutory agencies. The support allowed for wholistic packages of support and an understanding of the bigger picture and was seen to increase opportunities available for people supported. The multi-agency working also allowed a unified approach which also facilitated cross county working and the offer of more seamless support to people. This seemed to make things easier for external service providers too:

The provision had also helped heal and strengthen some previously difficult relationships:

It definitely helps understand the different challenges the different councils are facing, and maybe heal a bit of those wounds. Unfortunately, in the homeless sector, it's not like rivalry or anything like that, it's that desperate... you know everybody is so overwhelmed, you know, it just naturally ends up sometimes you pit yourselves against each other a little bit, I think this has really helped to smooth some of those relationships (Staff).

The partnerships allowed the sharing and pooling of information and skills. However, the co-ordination of services was also seen to be part of the success. There was recognition that sometimes multi-agency working could be over-whelming for some service users. To overcome this and challenges around engagement, there seemed to be informal arrangements whereby the person with the best relationship might facilitate other relationships. However, there was recognition that this could be more formalised through a case management approach. The care programme approach has worked well for a number of years in relation to those who are vulnerable because of severe or enduring mental health problems (Goodwin & Lawton Smith, 2010). This approach is about case management and ensuring that there is always one key worker with responsibility for a case, so that things do not get lost among a plethora of different interventions. This could provide a useful model to be adapted.

One area of joint working that still needs further development is in relation to social care. We spoke to one social worker who was developing a role that was very well regarded within RSI projects. Three other social workers came into post during this period. Several participants expressed frustration that, although they are registered social work professionals, these individuals are unable to access local authority social care administrative systems because of their role. This can be a prominent issue, particularly because safeguarding issues can be significant in the lives of homeless individuals. Recognising the importance of the issue, The Local Government Association recently produced guidance on Adult Safeguarding and Homelessness (LGA, 2020). Social workers and other key workers involved need access to relevant information in order to work most effectively in these situations.

3.7.2. Relationships with service users

Evidence from the literature suggests that relationships for people experiencing homelessness can often be problematic, with people experiencing homelessness often experiencing higher levels of isolation (often arising from a lack of trust), family ties being both positive and negative, the presence of searching for positive relationships and deference of intimate relationships (Padgett et al, 2008). Such findings highlight the importance of building relationships to ameliorate issues around building positive relationships and support networks.

People supported felt that staff were there for them. There was wide recognition of the complexities of building relationships with service users. Many had lost trust in services and re-building this took time. This was done through empathy, understanding, flexibility and the use of less formal activities.In building relationships, staff highlighted the importance of allowing people to make their own decisions, rather than just telling them what to do. It was also perceived to be important that people accepted support on their own terms. There was recognition of the importance of being understanding towards service users, even if they were shouting:

Staff felt the flexibility of the RSI model allowed for the human element to be ever-present in relationships and allowed for support to be person-centred. The small caseloads and flexibility in duration of support on many services allowed for the intensity of work required but also facilitated quality which impacted on relationships and outcomes:

I get more time to do intense work with people; so it improves the quality of work that I get to do with people, rather than just rushing around because my caseload is so high; and I think because I'm not restricted to how long I keep somebody on my caseload, it can be just sent it to the individual; that helps that as well, it's not like you've been on for six months and I have to sign you off now. So it is really tailored to the individual which I think helps with how they do the service (Staff).

Engagement was seen as an important outcome in itself:

A big outcome for most of our homeless clients is just engagement: if we can get them to engage with us, that's half the battle, and then other things will follow. With these clients and their complexities, if they don't engage, it's really difficult (Staff).

However, staff felt that job security and longevity of services was key to being able to build successful relationships and achieve positive outcomes.

3.7.3. Relationships with families and positive support networks

As highlighted previously, relationship issues were often a reason contributing to homelessness. However, relationships with families were viewed as important by many service users. Support networks could be important in reducing isolation for some service users and the provision of resources to support that was viewed as beneficial:

He wanted things like a bus pass. He got a bit lonely in the hotel where he is at. His connection was with people he had been drinking with. So we tried sorting them things out. We tried to sort out a mobile phone for him. And he's not doing brilliant as it stands, but at least he's got some kind of support network (Staff).

Where family support was facilitated, this could, on some occasions, support success:

He's in this new project now. And the main link with that was family support. I undervalued family support. His mum was an ally in all of that in terms of keep badgering him, pushing him, and supporting him ... what I have noticed is if you get the right family members, and they are attached to the support that you provide the professionals, that makes such a difference (Staff).

Table 15 below summarises self-reported contact with family.

	Females %	Males %	Total %
Yes, I have contact with my family and they support me	50.0	44.4	47.1
I have contact with my family but they do not support me	12.5	0	5.9
I have contact with some but there are others I'd like to have contact with	0	22.2	11.8
I know where my family live but I do not speak to them	25.0	33.3	29.4
I do not have any family	12.5	0	5.9
Children under 16? None live with them	25.0	33.3	29.4
Caring responsibilities?	16.7	0	7.7

Table 15: Contact with Family

Whilst there is significant literature on the importance of family instability in the initial prevention of homelessness, the literature on the importance of family relationships in moving past homelessness is limited. However, family ties are a significant factor in reducing the likelihood of offending and reoffending which is a risk factor for homelessness and therefore an indirect link to the importance of family ties, where appropriate, is indicated (Farmer, 2017; Social Exclusion Unit, 2002).

Theme 7: Relationships
Key Outcomes:

- Improved relationships between services within the RSI and RRP network and external to the network.
- Improved opportunities as a result of multi-disciplinary relationships and approach to support.
- Reduced barriers to engagement as a result of multi-disciplinary relationships.

Critical Success Factors:

- Excellent working relationships and sharing of knowledge facilitated by the RSI and RRP network of services.
- Multi-agency relationships utilised to facilitate relationship building and breaking down barriers to engagement with service users.
- Family involvement in support where appropriate.

Recommendations:

- A more formalised approach to utilising a single point of contact, case management approach should be considered.
- Ensure social care access to local authority IT systems to enable assessment, referral, and case management.
- The importance of exploring and facilitating family contact and support networks and involving such networks directly in the support to service users should be explored, whenever appropriate.

3.8. Theme: Accommodation

Within the data, there were several challenges in relation to accommodation access. These relate to the intensity of support required following accommodation being provided, barriers to accessing private rents, challenges of shared accommodation, challenges accessing other types of accommodation and a need for more of the right accommodation, particularly for people with complex needs. All of these points were also highlighted in many of the studies included in the literature review (Sheikh & Teeman, 2018; Mackie et al, 2017).

3.8.1. Intensive support required after accommodation

A clear need within the RSI model was a need for intensive support after someone had been housed and not just the focus on rough sleepers:

In a lot of cases, we are moving on to the next phase. If we just focus on rough sleepers, and luckily their numbers are getting less and less but it is not a limited part of our role to support people when they end rough sleeping, but it is not really defined how long. But you can't just focus on people who were rough sleeping (Staff).

There was widespread recognition that while housing someone was fundamental to supported them to move forward, it did not resolve their problems, and very often presented an entirely new set of complex problems which needed additional support to what was currently being offered. The intensity of this need was recognised as being highest immediately or shortly after someone moved into accommodation:

I think a lot of people in the first week or so of the moving into a property had they been rough sleeping, might be the time when they are at their most chaotic, and probably need the most support then; so early on identifying what they most need, what's likely to keep them in a place; to keep them from going back on the streets really (Staff).

The vulnerability of people in new properties was also noted with regard to the potential for targeting by people running County Lines within the County, and there was a need to build resilience to this. While the new NPRS Service provided support to people in tenancies, this support did not extend to supported accommodation. Supported accommodation providers highlighted that a large number of people who had been rough sleeping were asked to leave the service.

Supported accommodation providers felt this was a gap in services for the area. There was recognition that they could only do so much for people because they are not mental health or substance misuse professionals. There was a feeling that the intensity of support and priority access to services such as substance misuse intervention, mental health support and physical health support offered by RSI while someone was rough sleeping dropped off when someone was housed in supported accommodation, and this was a missed opportunity. There was a strong feeling that the intensity and prioritisation of RSI support needed to continue once someone was housed in supported accommodation such that their priority access continued in order to meet their complex needs. Allied to this was a feeling that professionals outside of RSI services did not understand rough sleepers as well and there was a need to increase this understanding:

It was felt an increased understanding would support the prioritization of access to services for people who had previously been rough sleeping:

I think sometimes having an allocation process by those people can be prioritised; so we can get them at their most open to change, rather than waiting for them to go and sit and change back into our behaviour; so for me it's just about being more informed and a better understanding and better trained if you like; and then also having aspects of the service which is a lot more responsive; quick response to getting people through the system, to get them in and registered and referred; that would be my main thing really (Staff).

The importance and cost effectiveness of rapid and intensive accommodation support has been demonstrated in trials in a number of countries (Latimer et al, 2019).

3.8.2. Barriers to private rents

Although engagement with and support to landlords was identified as a success factor (See section 3.10), there were significant problems with access to private rented properties.This was exacerbated by multiple barriers, predominantly around requirements for guarantors, low acceptance of people in receipt of benefits and costs of renting. Although the private rented sector has increased considerably in the last few years, it has been shown that access to the sector remains severely limited for people experiencing homelessness (Reeve et al., 2016). This was linked to suggestions that private rented accommodation was rarely a suitable option for people who had experienced rough sleeping, and particularly those who had experienced entrenched homelessness. This was seen as paradoxical to the expectations of society and the government that private rented accommodation is a suitable long-term housing option, and it was felt that it was maybe only an option for professionals or people accessing temporarily. It was felt that this was not helped by the stigma and misunderstanding of accepting people in receipt of benefits and the inaccurate association of being in receipt of benefits with poor behaviour.

It was further compounded by landlords being concerned about accepting people with a history of drug use. There were also concerns about the use of private rents for specific groups of people such as those who had experienced domestic violence and people who were older, due to the potential for lack of stability:

I'm not saying they should or I'm not saying they shouldn't, but is it necessarily ethically right to be encouraging a single mum who's fled domestic violence into a tenancy which is only guaranteed for six months, and she may have to move again, and she'll be in the exact same situation (Staff).

There was some concern about the standard of properties that would be let to people in the RSI rough sleeper client group. The RSI support had been able to try to address some of these concerns to a degree. A recent national scoping project thoroughly evaluated the barriers to private rented accommodation and arrived at similar conclusions (McAuley, 2020).

3.8.3. Pets

Pet companionship can provide several benefits to a person experiencing homelessness, including companionship, safety, a sense of responsibility, social identity, and improved emotional and mental health (Cleary et al., 2020). However, the relationship can also add challenges, including decreased shelter availability and emotional vulnerability relating to fear of losing their companion (Cleary et al., 2020). Pets were seen as a challenge to overcome in terms of accessing accommodation in our sample. There appeared to be a downturn in the number of providers allowing pets into properties. However, staff recognised the significance of relationships with pets, both within families and with single homeless people, and the need to try to accommodate them:

However, there was also recognition that allowing pets was a legitimate concern for landlords, for example:

Yes, it definitely rings another alarm bell with the landlord, doesn't it? Is the pet going to cause damage to the property? I think some landlords are now asking for an extra deposit, if there is a pet involved; and that feels like fair comment to me. I mean, if the owner is going to make sure that the pet is behaving, then are not an issue really (Staff).

3.8.4: Shared accommodation

There were very mixed views on the suitability of shared accommodation. Many participants preferred to live alone. Shared accommodation seemed to be more widely available than one-bedroom properties:

There's not really a lot of flats in Mansfield because they don't really make a lot of money. Sort of one-bedroom flats, and I just don't think the housing stock has a lot of room for one-bedroom flats, so your options are a family home, or shared accommodation (Staff).

Age could be a differentiating factor in relation to the perceived suitability of shared properties, with references made to inappropriate shared accommodation being offered to individuals in their 60’s and 70’s. For others, shared housing was appropriate at times, could have the benefit of being furnished and could result in being housed quite quickly. In addition, it was felt that for some people there were no other options due to cost.

Shared housing particularly caused challenges for people with children and the spaces were not often suitable for children to visit. It could also cause longer term problems of dependency and problems for the local community:

The multi-occupancy sometimes creates a culture of further dependency and an extension of what was on the streets. It can complicate things and lead to people picking up new habits. It can be difficult for staff to manage (Staff).

There were also specific risk and safeguarding issues with some mixed sex shared accommodation:

He has gone into shared mixed sex accommodation where there is people that are using, exploiting, grooming. This will all be happening subtly under staffs nose. The moment we get somebody in there we need to do really intensive work to get someone in their own accommodation (Staff).

The issues with shared accommodation were not specific to the private rented sector but also applied to supported accommodation. The debate about shared versus single housing caused quite a debate in our interviews. However, a US based study evaluated longitudinal data on 6000 formerly homeless individuals and found that shared living arrangements compared to living alone did not adversely affect individuals, and in relation to some mental health outcomes at twelve months was actually beneficial (He et al., 2019).

3.8.5. Barriers to other types of housing

There appeared to often be a lot of potential options available initially, but once explored, these were not accessible by the client group. Often this was related to perceptions of risk, or assumptions based on previous behaviour. It should be noted that sometimes there were barriers to accessing other types of properties, not just private rented accommodation. This included housing association lets. In addition, there seemed to be differences in terms of local authority responses to housing applications, particularly regarding establishing local connection and priority need.

3.8.6. The need for more of the right accommodation

Several suggestions were made about how access to accommodation could be improved through the availability of the right accommodation. Firstly, more flexibility in the offer for flats:

They need to be more innovative; build better properties, build flats which are maybe a one bedroom which can be turned into a two bedroom if need be; and start building more stock on these housing developments (Staff).

There were suggestions that more complex needs accommodation was required. There were also suggestions that the current supported accommodation and even the complex needs accommodation was not enough for some people. There was felt to be a need to have a hostel with 24-hour staff that could fully support people with complex needs. One review of the literature found eleven studies supporting the effectiveness of emergency accommodation (Munthe Kaas et al., 2018). Another review was more sceptical about emergency accommodation such as hostels (Mackie et al., 2017). The different perspectives are not incompatible. Hostels can be effective to meet short term needs if offering intensive support from well trained and experienced staff. If not, then high rates of abandonment and eviction can occur. It was felt there needed to be more accommodation but also that intensity of support needed to continue through someone's journey across different types of accommodation and into move on. There were also some suggestions for an emergency accommodation provision:

What would be amazing is if we could miracle some emergency accommodation from somewhere; because we haven't any emergency accommodation. If we could miracle a great big hostel somewhere, but hopefully we will have no need for that soon (Staff).

Theme 8: Accommodation
Key Outcomes:

- A range of accommodation accessed across the RSI and RRP network.
- Work undertaken to break down barriers to private rented properties.

Critical Success Factors:

- Access to the right accommodation for the person's circumstances.

Recommendations:

- To build on the success of the intensity and prioritisation of support offered through RSI services and ensure momentum is not lost once someone moves into supported accommodation, prioritization of service access should be continued post-transition.
- Commissioners of RSI Services and RSI staff need to keep in mind that private rents are not suitable for a significant group of people accessing RSI Services.
- Increase opportunities for people with pets to be housed.
- Shared accommodation should be made available to people, only when it is the right option for them.
- Organisations should be challenged in relation to decisions made on the basis of historical behaviour or risk information that does not consider individual capacity for change.
- There should be a unified approach across local authority responses.
- The complex needs provision should be expanded to offer more capacity, greater intensity of support and 24-hour support.
- Suitable move on accommodation from complex needs accommodation should be available.

3.9. Theme: Personal Budgets

In terms of success factors, several participants highlighted how well personal budgets had worked for several individuals:

I think the most obvious is the rent up front, deposit, kitting a flat out if they need new furniture and stuff; but I like to be creative with it so particularly because it's with people with mental health; gym memberships I found are really good. I've found people struggle with ways to fill their time, and especially the nights, so 24-hour gym membership is great because they can go at 2:00 o'clock in the morning if they want to. Even little things that don't necessarily cost a lot but like colouring books, and all those kind of materials, to help distract from self-harm; anything really, if I can justify that it's going to benefit their mental health then I will do it (Staff).

Our findings are supported by the literature. Since personal budgets were first introduced in social care, there has been evidence that they can be successful, particularly when used with mental health service users (Larsen et al, 2015). The review by Mackie et al (2017) found good evidence for the use of personal budgets in the homelessness sector.

Theme 9: Personal Budgets **Key Outcomes:** • Supporting individuals to furnish housing. • Support to purchase goods and activities to support mental health.
Critical Success Factors: • Ability to access funds quickly and to be able to use funds flexibly to meet individual need.
Recommendations: • Make personal budgets available to as many service users as possible.

3.10. Theme: Landlord Support

Landlord support was prevalent throughout our data collection. Landlord support was offered through RSI services as a preventative model. Evidence in the policy literature indicates that such models are welcomed by local authorities due to growing numbers of statutorily homeless households (Pawson, 2007). Such preventative schemes include enhanced housing advice including liaison with landlords, rent deposit and related schemes, and tenancy sustainment (Busch-Geertsema & Fitzpatrick, 2008). This was aligned to the findings of the current research.

Landlord support goes some way to mitigating the challenges of private rents but does not overcome the challenges completely. The key factors in relation to landlord support were liaison with landlords, specialist support for the landlord as the client, and access to funds to support access to private rented properties.

3.10.1. Engagement and Support for Landlords

Landlord engagement and support was an extensive feature withing RSI and RRP Services, providing support to Landlords via Call B4 You Serve and Landlord Liaison Officers. The services were provided free of charge and were able to advocate on behalf of landlords, mediate between landlord and tenant, and have difficult conversations with tenants where required. This often resulted in maintaining tenancies or avoiding evictions:

The Call B4 You Serve service provided preventative support:

Recently I'm getting, I will call it, upstream prevention. We are getting involved in the early stage because you are probably aware that landlords can't serve notice now for six months. So obviously with homelessness, I think it's two months before . . .their tenancy comes to an end. So what happens there is that they are referring someone to me as soon as they walked through the door at say Mansfield, they send a referral through to myself, the idea being we can work on that case, before they go back through the door. So we're doing a lot of prevention work now (Staff).

A further example of the support is provided in the case study below.

Case study of Call B4 You Serve Support

The situation:
The landlord's tenant had gone into hospital due to a terminal illness. As a result, the rent had stopped being paid. The landlord had been unable to get any additional information due to GDPR and the social care team did not appear to understand the need. She did not want to go to court as that would result in a loss of deposit for the tenant and additional costs. She also did not want to dispose of the tenants' items. The landlord was aware of Call B4 You Service because she was an accredited DASH landlord.

It was quite upsetting really, I wanted to do the right thing, but there were lots of obstacles in our way. The only way we could get rid of the tenant legally was by court, or if he ends the tenancy himself which at the time he was not of sound mind to do (Landlord).

The actions taken:
The officer was able to liaise with adult social care who were looking after the tenant and set up communication between the two parties. The officer kept in regular communication with the landlord.

The outcomes and impact:
The landlord was able to get her property cleaned and returned to her. The landlord did not have to go to court, the tenants' belongings and deposit were returned to him and he was successfully moved into nursing home accommodation.

It was a godsend to know there was somebody that could actually help because we would have been stuck (Landlord).

The reported feedback from landlords was positive because they were not having to go to court, they were not having empty properties and they were able to maintain tenancies. The services were able to reassure landlords and also sell the prospect of letting their property to people who access support, whilst preparing people for renting by supporting with finances. The reassurances were provided to both landlords and prospective tenants.

The Landlord Liaison Service provided an end-to-end service and reassurance from referral to resettlement, once the tenant had moved in:

I take referrals. I complete assessments to see how suitable they would be for the service. I complete viewings on behalf of tenants. I'm trained under the housing and health and safety rating system, so I give it a bit of an inspection as well. I liaise with landlords a lot; so I do a lot of negotiating, explaining; talking about benefits and things like that. And I also provide like a resettlement service (Staff).

The support provided not only saved tenancies, but it also supported increased availability of tenancies. There was recognition that the support and reassurance had a snowball effect, such that other landlords would also come on board. There was also recognition that building up the relationships with landlords could take time:

I think if they've been burnt in the past, then it's a real hard battle, and it takes time to win their trust; but some are open to it (Staff).

The services were also aware of particularly understanding landlords who were willing to accept people who had experienced homelessness. However, there was also recognition of the opportunity to change the perspective of, and increase understanding, amongst other landlords. The staff also supported landlords to overcome concerns such as liaising with the council and needing to have health and safety inspections:

Some landlords are a little bit hesitant in the sense of – Oh, I don't want to work with the council. Our whole kind of mantra, really, it's just kind of re-framing those thoughts, and just thinking about it in a different sense; trying to encourage them not to think of the council as this ogre that's going to come and enforce a prohibition order on their property, or something like that (Staff).

From a landlord liaison perspective, there was also the importance of supporting prospective tenants to access properties which may otherwise have been difficult due to lack of confidence or other challenges in their lives. They would smooth the communications with potential landlords to try to ensure they felt more comfortable accepting the tenant. On a practical level, services would liaise between the landlord, the tenant and the DWP to arrange for benefits payments to be paid directly to the landlord.

The Call B4 You Serve service was also seen as best practice:

Plus the MHC advertises us a lot because they see it as best practise, what we are doing; they acknowledge the fact that it does work, and so we're getting a lot more publicity through them as well (Staff).

However, whilst the support and liaison with landlords appears to have been successful to a degree, the data also highlighted significant issues with private renting for some groups of people (See section 3.8.2).

3.10.2. Funding for private rents

Allied to the success of support offered to landlords, there appeared to be some success relating to the provision of funding for private rents, and this was helpful in securing properties without pushing people into further hardship. Additionally, in the Housing First Service, funding extended to being able to buy items for someone's property:

So, the fact that we provide them with a home, it's not just a property; so council houses are empty shells: you've got no curtains, no blinds, no carpet. If somebody was on a basic UC of £53 a week, they're never going to have some way that they can actually say – This is my home. And it looks like a home. And I think that is a massive thing. I think with Housing First that is a big thing for them, making a house a home (Staff).

However, this was a potential gap outside of supported housing or the Housing First model:

Theme 10: Landlord Support **Key Outcomes:** • Reduced court proceedings and evictions. • Increased access to private rented properties.
Critical Success Factors: • Landlord as client via specialised service. • Landlord support separate from local authority. • Landlord liaison as a communication link between landlord and potential tenant. • Access to funding for rent deposit, rent up front and to set up home.
Recommendations: • A sustainable approach to access to funding to support private rented access should be offered.

3.11. Theme: RSI and RRP Network

This theme highlights specific elements of the RSI and RRP network that have not already been discussed in previous themes, namely the SOT, NPRS (navigator support), Housing First and the Cold Weather Fund.

3.11.1. Street Outreach (SOT) – intensive and flexible support

The literature review showed that a key element of 'what works' to best support rough sleepers is the assertive and intense support offered via a street outreach way of working (Mackie et al, 2017). The support received from the SOT was received positively by service users who we spoke to. The speed of support and just having someone reach out was particularly appreciated.

The partnership of SOT working alongside CGL on an out-reach basis worked cohesively to address substance use needs, whilst facilitating faster access to accommodation:

CGL with their outreach workers as well, the drug services, they've got outreach workers …who are RSI funded. So we work really closely with them. They come out on early morning outreaches; they do a lot of visits with us, yeah really good. So we can kind of fast track if somebody needs to get on a script, like a methadone script, we can get that fast tracked. Which then fast tracks their accommodation as well (Staff).

The outreach support was able to bring services together by providing a link to support people. The ability to offer practical support relating to basic needs around clothing, access to warm items and access to a phone, alongside emotional support and encouragement was fundamental to how people felt. Being able to ring into the SOT was also very much valued and people felt that if they did ring, they would be helped.

The persistence of the outreach approach balanced with relationship building and not telling people what to do appeared to be positive. It was important that SOT was able to take the support to people, rather than expecting them to come to the service:

There was one guy in particular, that we met under a bridge…he was injecting into his neck, he was living with two other rough sleepers, they were defecating and living under this bridge, and the room they had between them and a riverbank was about a meter, I would say, and how they were sleeping in the height of winter in the cold. The guy who we engaged down there, he is now in full time employment, and he's two years drug free, and I keep in regular contact with him (Staff).

Allied to this, the SOT and accompanying CGL service was able to flex to meet the needs of the person rather than the person having to fit into existing parameters of a service. This flexibility extended to timeframes for support, the ability to re-engage with people where needed over time and the ability to over needs-led, person-centred support. The assertive outreach nature was also appreciated by local authority partners.

On occasion, the flexibility of support provided by the combined SOT and CGL outreach, facilitated the ability to move people out of area. This was particularly important, given some of the challenges faced by people trying to leave the streets, as outlined earlier:

We linked that in with an accommodation provider, and then we'd move people…we wouldn't just dump them out of area, but what worked with moving them out of area, you kind of removed them from where they were trapped in a local area, the idea was that you could stabilise and hopefully start building …they are now engaging in things like going swimming; things that we might take for granted that they've never done (Staff).

3.11.2. Navigators

Navigators offer co-ordinated support to people out of prison, out of hospital and away from homelessness, and are seen as a vital part of helping people with the most complex needs to move away from rough sleeping (MEAM, 2018). Key features of successful navigator practice include reporting to a cross-sector partnership; and having the assertiveness to request flexible responses; having the time and flexibility to build relationships and follow individuals throughout their journey; having personal attributes such as compassion, resilience, and aspiration; the ability to engage with hidden groups including women and people from ethnic minority groups; a focus on changing systems and not just providing support; a focus on engaging existing services, not providing new ones; and having the right training and supervision including an awareness of trauma (MEAM, 2018).These features were largely reflected in the practises highlighted by the current research.

A team of navigators were a key part of the RSI network. The team, called the Nottinghamshire Prevention and Resettlement Service (NPRS), comprised of a prison navigator to liaise with prisons pre-release and support people through the gate; a mental health hospital navigator to act as point of contact for psychiatric hospitals and to support hospital discharge; and four tenancy navigators to provide floating support to people once they had been accommodated, or to support existing tenancies to be maintained. Although much of the navigator team were just becoming established, the importance and value of the navigators within the RSI model was reported:

I think the work between the outreach team, and then your navigators, and the mental health navigator, and the CPN's, and the substance misuse CGL's in outreach, I think that collaborative work from what I've seen over the years, how it's improved, you know, when there's more funding from on services; so now the housing navigators have come on, when somebody leaves the street through outreach, they can then refer into the housing navigators to ensure resettlement (Staff).

This was viewed particularly positively in relation to the prison navigator. They had been able to develop important and meaningful relationships with prison resettlement and probation, and this was vital to being able to intervene prior to release and to know if people had been recalled to prison.

However, there was recognition of the whole navigator team to support partnership working, facilitating access to people in prisons, liaising with people in hospitals and supporting resettlement.The navigator team moving forward will be able to support people once they are accommodated and it was felt this would take the pressure

off other upstream services trying to continue to support resettlement while having new people coming onto their caseload.

In addition, the preventative role of the navigators was recognised. Importantly, there were no barriers to accessing the service due to risk or need. While the navigator support appears to have been positively received and existed to support clearly identified gaps in the RSI network, there may be some concerns around capacity. Even though the tenancy navigators were quite a new team, there was already a waiting list starting to build. This was partly due to the team's commitment to provide intensive quality support to those already on the case load.

This was reflective of the fact that the people referred had complex needs. Such complex needs were particularly prevalent in the early days of a tenancy. Although it should be noted that the prison navigator reported no waiting list, the single prison and hospital navigators also covered large areas and multiple sites.

The suggestion that HMP Ranby is the top referring prison may be reflective of the fact that Ranby is a designated resettlement prison, however, reports from HMP Nottingham indicate that a quarter of their releases have no accommodation (Independent Monitoring Board, 2019). The lower referrals from HMP Nottingham could also be related to the fact the navigators and RSI Services do not cover Nottingham City. However, the likelihood is that people referred from HMP Nottingham would travel countywide and so there may be an opportunity for further relationships and partnership working to be developed with HMP Nottingham, with an increased prison navigator capacity.

Despite the building of a waiting list in the core team, and limited capacity, the RSI network did allow some mitigation of this because other services were still available to support, and the team were keen to ensure regular communication in relation to this:

So we will always reply to the referrer that this person has been accepted and we will work with them but just because the caseload we've all got at the moment, and the limited capacity we've got, we are not able to offer them the support at this moment, but when we can we will inform you. We want to be able to support everyone, but it's just not possible. You are always limited by staff, any service where there is a waiting list (Staff).

3.11.3. Housing First Principles

The Housing First model had not been established long in the region during the research period and was only available in Mansfield. There were several key features within the Housing First model which existing literature has shown as crucial to success for working with rough sleepers: Low case load and intensity of support, working on multiple needs to provide wholistic wraparound support, access to personal budgets for setting up accommodation, practical support within tenancies and empowerment and long-term support and accommodation (Mackie et al, 2017).

There were also future plans within the Housing First model which had been delayed due to COVID-19 but that would further benefit the people supported through supporting to develop life skills, and further support a person-centred approach.

3.11.4. Winter provision (Cold Weather Fund)

The challenges of remaining on the streets were discussed by people being supported, particular during cold weather periods:

They expect you to stay in it, because it's above minus, they expect you to sleep outside. At the end of the day, even if it's 2 degrees or 1 degree, it's absolutely perishing; it's just hard keeping warm (SU).

However, the intensive support offered under the rapid rehousing pathways seemed to alleviate this for some. It provided an opportunity to support multiple needs, intensively, for a brief period of time while someone was safely accommodated. This chimes with findings from other studies which illustrate that up to 86% of people are found accommodation after a first night, when using similar rapid rehousing schemes such as 'No Second Night Out', and only 22% return to the streets (Homeless Link,2014). This finding is highlighted in other reviews included in our own literature review and shows the importance of this type of rapid, time critical intervention. However, the cold weather provision did not appear to be open to everyone in Nottinghamshire.

Theme 11: RSI and RRP network **Key Outcomes:** • Increased engagement in services for people who are rough sleeping. • Access to intensive housing support under RRP provision.
Critical Success Factors: • Services taken to the person, regardless of location while rough sleeping. • Needs-led, person centred, flexible approaches. • Access to navigators to support transitions and prevent future homelessness. • Intensity of support within Housing First approach.
Recommendations: • Explore opportunities to build a relationship between the prison navigator with resettlement and probation services at HMP Nottingham. • The newer initiatives such as the NPRS and Housing First were still being developed and it is recommended that these are more fully evaluated in the future. • RSI Commissioners and Managers should investigate the outcomes achieved through the Rapid Re-housing pathways provision and consider the adoption of similar models, where appropriate, for the wider homeless community. • Increase the capacity of the NPRS Team. • Expand Housing First to other areas of Nottinghamshire.

3.12. Theme: Foreign National Clients

We did not interview any known foreign national clients within our sample. However, staff participants commented on the challenges and needs within this group which included ESOL needs, no recourse to public funding and use of translational services.

3.12.1. ESOL needs

Difficulties were discussed in accessing support for people with ESOL needs:

Just the mental health side of things, I think. I guess it's a difficult one to answer because there are somethings that I could be doing, but actually the funding, there are things that could be done in terms of IT skills and everything being online; and so due to COVID, and everything going online, it's been more difficult for my clients to access certain services; For instance, ESOL classes. They've all gone online; and not all of my clients can even use their phone not alone use their phone to access a course. I spent an hour of the day with the lady who translates for me trying to download WhatsApp on one of my clients phones just so we could do a video call with them and do some conversational classes; but you're hoping to do in the future. It was all in Russian and we literally couldn't download it, there was also some messages coming up which we didn't understand (Staff).

3.12.2. No recourse to public funding

The issue of eligibility for public funding has been a significant and at times controversial one in relation to rough sleepers who are not British Nationals. Clients with no recourse to public funds are at high risk of homelessness and destitution because they cannot access mainstream housing, welfare benefits and employment (Homeless Link, 2020). Services can find it difficult to engage with clients with no access to public funds due to the limited support options available.

Participants came across this issue regularly. No recourse to public funding is a complex issue and a person without recourse to public funding may still be offered support by local authorities and other services. However, achieving a status which does give access to public funds means that individuals are more likely to gain a wider range of support. We were made aware of discussions at the steering group about the importance of the issue and the example of one worker in Newark who had been able to locate 21 individuals and assist them to achieve settled status and thus access to public funding and services. It was highlighted that there were on occasion incorrect assumptions made that people did not have recourse to public funding when they did:

I think the assumption is that they will have no recourse to public funding, but actually what I found with the clients I work with, they just not applied, they've been in the UK for long enough and they are able to work, and they're able to apply for Universal Credit. And so with some of them just working with them to apply for Universal Credit so they can get some housing, or mainly trying to find them employment, so they can get housing (Staff).

3.12.3. Use of translation services

Support for those who do not have English as a first language was discussed above. Such support can be particularly important and useful when individuals have mental health issues but are unable to communicate and they do not have physical symptoms that can be independently measured (Kroulek, 2019). The need for more accessible translation services was highlighted by a number of participants.

Theme 12: Foreign National Clients **Key Outcomes:** • Supporting individuals without English as a first language into accommodation, and signposting to other support services. • Maximising income through thorough checking of status in relation to recourse to public funding.
Critical Success Factors: • Availability of translation services. • Clarification and proper application of rules on no recourse to public funding. • Assisting individuals to gain 'settled' status where possible.
Recommendations: • Access to funding for affordable and reliable language/ translation applications or services to meet diverse service user population in Nottinghamshire. • Access to funding for IT and technology for service users to engage in ESOL classes. • Thorough checking of a person's status with regard to recourse to public funding should be under-taken to ensure maximisation of income which may support them into accommodation.

3.13. Theme: Staffing

The staffing within RSI and RRP was fundamental to its success factors. This section explores the staffing issue further with regard to experience, training, and welfare.

3.13.1. Staff Experience

The RSI services were staffed by people who were passionate about their job, who viewed working on RSI positively and who typically had extensive previous experience, including lived experience. The diversity of experience was also valued:

Bringing passionate people through like [redacted], they have got good lived experience. That has been invaluable. You don't always get that. If you can get that blend. I will be a bit controversial here C, people that have maybe not got a great life experience, and sticking to the safety of the protocols, they will not connect with the clients and without people connecting you are not going to see them moving forward (Staff).

The length of experience was also seen as important in engaging and supporting people successfully. For example. It was also noted that service user involvement was present within some projects such as the YMCA accommodation. This not only facilitated communication but also provided opportunities for people accessing services to be upskilled in preparation for the future.

Other studies have also shown the perceived value of experience, including lived experience of rough sleeping, for those working in this field (Peters et al, 2021).

Case study – Service User Involvement

The situation: 'B' had been rough sleeping for a period of time following the breakdown of family relationships.

The actions taken: Intensive support given, including in relation to mental health issues. Housing was offered by the YMCA. After living in the YMCA supported accommodation for over one year, B was elected as a resident representative.

The outcomes and impact:
B felt that people opened up and talked to him and that the opportunities provided would assist him into future work. He summarised this in the following quote:

They gave me the opportunity to work, to get me used to working again, So I am resident rep here…It was nominated to the top 2, and I was one; and then I had to have an interview, in which I succeeded…everybody talks to me… I do the reception work as well ... I'm doing this because they said if I can get the experience now, then six months after I leave the YMCA, I could be getting a job up here permanently. I'm setting myself up by doing this ('B,' SU).

3.13.2. Staff training

The previous section suggested the importance of experience (including lived experience of homelessness) for successful work in the kind of projects funded by RSI/RRP. Such experience can provide an excellent opportunity to develop the kind of skills and attitudes necessary to the work. There is also an important place for formal training for staff. We have talked in earlier sections about the prevalence of mental health and substance misuse, and histories of offending and of trauma. Without becoming a specialist, there is a place for training for front line staff in these areas. For example, in relation to mental health, the Mental Health First Aid programme has become a widely adopted brief training which can help any individual who encounters a person with mental health problem. It can help particular in terms of knowing how to recognize and acknowledge issues, and how and where to signpost people for further specialist help. Evaluations consistently show that MHFA training is associated with improved knowledge of mental illnesses and their treatments, knowledge of appropriate first aid strategies, and confidence in providing first aid to individuals who may be experiencing mental ill health – benefits which are maintained over time (Mental Health First Aid England, 2020).

The concepts of psychologically informed environments (PIE) and trauma informed care have been referred to. These ideas have gained a lot of traction in homelessness services (Homeless Link, undated) and training in these ideas is becoming widespread in the sector.

One participant made the key point that more than training for individual staff is often required. That may be a necessary but insufficient driver for necessary changes. Ongoing reflection and also changes in systems and policies which fit with how staff are being trained can be important:

Psychologically informed environments. So, I think it is full of dilemmas, it needs lots of reflection; so I think training is part of it, but the training is the absolute basic foundation, and it's the ongoing space to reflect to learn what works and what doesn't about individuals generally; and it's about every level of the organisation, and the organisations around. So, a lot of the Opportunity Nottingham work is focused on the systems change work, because it's all very well having staff who are trained in PIE, but then if they are working to systems and policies where they are not allowed to implement that thinking, because there's no flexibility, because housing management say – This behaviour leads to eviction (Staff).

We were informed of what seems to be a useful recent training initiative, bringing some existing training online and making it available to staff across the county. The PDU (Practice Development Unit) is located in Nottingham, and is part of Opportunity Nottingham, but held at the NCVS, the voluntary services training around multiple disadvantages. A series of online modules have been launched that are free to access: e-learning modules, offering a basic introduction to PIE, TIC, brain injury and other issues that are relevant to individuals that sleep rough.

One participant commented that the PDU is a really useful hub to try and bring people together, share dilemmas and ideas and to help think about how you meet some of the complex needs of the population.

3.13.3. Staff Welfare and support

The type of 'emotional labour' involved in this kind of work can take its toll and risks of stress and burnout are a real issue in front line public services that needs to be acknowledged. Literature has also identified that vicarious trauma can affect those who have to witness or hear about trauma on a very regular basis, and rates of vicarious trauma and PTSD are reported to be high among staff in the homeless sector in the US (Schiff and Lane, 2019).

Some of our participants in this evaluation acknowledged the issues:

I did some training recently as a pilot to a small number … that work in the city with this population, around trauma informed care understanding. Trauma not only for individuals who are rough sleeping, but also for a personal professional wellbeing perspective, because again the workforce have to be absolutely at the centre (Staff).

In other evaluations we have found that factors which mitigate against perceived stress and burnout include good supervision and buddy systems in the workplace, but also crucially having a good degree of autonomy and control over the parameters of the work (Rogers et al, 2020). This confirms findings in the wider literature on stress and burnout. The encouraging news is that, like us, other authors found that despite high workloads and often high levels of stress, workers in the UK homeless sector expressed a high degree of job satisfaction and there was little evidence of burnout (Lemieux-Cumberlege, & Taylor, 2019).

Some staff commented that it would be nice to get more recognition of the valuable role that they play. Sometimes negative attitudes from the public were difficult to deal with, and some felt that there was insufficient acknowledgement from funders:

Maybe something from the commissioners to say what they think of us, what we are doing. We don't get a lot of that (Staff).

Theme 13: Staffing **Key Outcomes:** • Outcomes for service users in terms of employment in the sector.
Critical Success Factors: • Employment of staff with a good mix and length of experience of working in the sector. Using views of staff and service users to inform service development.
Recommendations: • Utilise the extensive experiences of staff and service users to inform future service development. • Buddy systems to support staff welfare. • Provide opportunities for reward and recognition within the staff teams.

3.14. Theme: COVID-19 Impact

When the Government introduced restrictions in March 2020, services had altered their delivery almost overnight. This was not unique to services supporting people who were homeless but critical decision-making was required to balance the needs and safety of people supported, with the safety and needs of staff. Some of the impacts of this were drawn out through the current research, as outlined below.

3.14.1. 'Everyone In'

The 'Everyone In' Scheme, sometimes referred to as the 'Everybody In' Scheme, was a government scheme which helped house thousands of rough sleepers and get them off the streets during March 2020 when the COVID-19 pandemic hit the United Kingdom. There have now been a number of reports and evaluations which have analysed what was successful about this scheme (BMA, 2020; Homeless Link, 2021; LGA, 2020).We heard from a number of participants that the scheme had accelerated moves off the streets for many individuals and had been very helpful for many. Some participants were concerned, though, that some individuals returned to the streets, because there was not the resource to offer the intensive support necessary, as well as accommodation:

Some have gone back on the streets, some haven't. I would say 50/50; some have stayed in accommodation, some never stayed for the duration. I think it was June the 19th that that ended, and the weren't many people that had kept it for that long (Staff).

Some struggled in transitioning into being housed and others refused to engage in the support offered. Despite the initial success of the 'Everyone In' and the growing severity of COVID-19, the scheme was not continued during the second and third lockdown.

3.14.2. Partnership working during COVID-19

Good partnership working that had been established continued throughout the COVID-19 restrictions. Unsurprisingly, some difficulties were encountered but most participants said that these were minimal:

The only issue we had working with other services during COVID-19 has just been the accessibility and having to find different ways to get information for risk assessment. There hasn't been major things, it's mainly been about external agencies, that we've had real problems getting information from and there's nobody there, or everybody is off again (Staff).

3.14.3. Medication and script distribution:

Another crucial policy change during the COVID-19 pandemic was the distribution of prescription medication:

There was a write up about our outreach last month; it was about all the stuff we were doing extra. We had to diversify. We've been asked to do well person checks. When a drug worker hasn't been able to, somebody will drop off scripts, the drug worker hasn't been able to get hold of them, so myself and C will go and do a well person's check. We've done about 30 to 35 of those (Staff).

So diversifying outreach is something we are supporting; supporting a lot of people who are struggling generally; stuff we wouldn't normally do anyway. The big thing as well is when the first lockdown started and the post office shutdown, we've got about 3000 people on prescriptions; so, we took on board to deliver all those prescriptions to pharmacists around Nottinghamshire (Staff).

Theme 14: COVID-19 Impact **Key Outcomes:** • Good support to individuals to get off the streets and housed during 'Everyone In.' • Good support from street outreach to maintain continuity of prescriptions.
Critical Success Factors: • Established good joint working relationships are particularly useful during crisis.
Recommendations: • Develop post-COVID-19 plan to establish what learning can be taken and what practices will remain and utilise this to develop an established protocol for future pandemics and working with rough sleepers.

4. Outcomes Monitoring Framework

Any outcomes monitoring framework (OMF) must account for the multitude of hard and soft outcomes achieved by the network of RSI services, as outlined within the main body of this report. The OMF also needs to account for individual outcomes, specific to circumstances. The framework also needs to account for change in services and needs over time. A multi-dimensional outcomes monitoring framework is suggested to capture the breadth and depth of activity across RSI and RRP services. The framework has three main elements:

1. Public services data
2. Service level outcomes monitoring
3. Individual level outcomes monitoring

Our suggested monitoring framework distinguishes between service level monitoring and individual outcome monitoring as a way of ensuring that both hard and soft outcomes are counted. Suggestions for the specific indicators for each element have been made but these should be refined in consultation with RSI and RRP strategic stakeholders and staff. A series of workshops could be held to facilitate these discussions.

Recommendations for Outcomes monitoring

- We recommend that commissioners and individual service providers consider the elements of outcome monitoring described below and evaluate how these might best be incorporated into contracts, routine service monitoring, and day to day practice.

4.1. Public services data

This strand of the framework arises from the data outlined above, supported by evidence from the literature in relation to the complex needs of people who are homeless and rough sleeping. These complex needs can result in increased usage of public services including criminal justice, health, and social care services. Outcomes monitoring frameworks should include the facilitated information sharing to allow the monitoring of calls to emergency and public services (particularly police and ambulance) relating to people rough sleeping and/or accessing RSI Services. This would allow for analysis of whether access to RSI services reduces this and to identify increases in calls over time. Identified increases in calls would highlight the need for further investigation to examine and overcome the cause. It is therefore suggested that the following outcome indicators in relation to use of public services may be useful to support the impact measurement for RSI and RRP Services:

	Monthly average data		
	Pre-support	**During support**	**Post-support**
Hospital data			
Number of ED attendances			
Police data			
Number police incidents			
Number of arrests			
Number of nights in police custody			
Court data			
Number of court appearances			
Prison data			
Number of prison entries			
Mental health service data			
Number contacts with crisis service			
Days spent voluntarily admitted			
Days spent detained involuntarily under MHA			
Social care data			
Referrals to adult social care			

Table 16: Public services outcome indicators .

It is suggested that the data be collected for individuals accessing RSI services pre-support (retrospectively), during support and post support. Pre and post periods could be defined as 3 months, 6 months or 12 months but should be applied consistently. It is recognised that such a framework does pose challenges, particularly in relation to the complexities of information sharing, requiring strategic co-operation across public services. However, such data has been utilised successfully in other multi-agency approaches to supporting people who are vulnerable and is likely to prove useful for cost-benefit analysis and hard outcomes to support future commissioning arrangements.

4.2. Service level outcomes monitoring

The service level outcomes monitoring element is designed to provide data across the pathways supported by RSI and RRP Services (see Table 17). The outcomes suggested are based on the pathways to reducing offending which have previously been adopted by criminal justice and allied agencies, integrated with the findings from this evaluation. It is recognised that not all of the outcomes will be relevant to all services, but it is suggested that relevant outcomes are collected for each service monthly to allow for analysis in trends over time. As outlined above, the specific outcomes should be refined in consultation with staff and other stakeholders. The data should be collected for all services, including specific support from services such as the tissue viability nurse and CPN but aggregated across all services. To support, the quantitative data, there is the opportunity to collect qualitative data to provide a bank of case study evidence for future training of staff and commissioning, whilst also providing the opportunity for continuous service development. Teams should provide the data in consultation with all staff members (e.g., via monthly team meetings) to gather a 360 view of what is working well, what is not and what needs to happen. Continuous service development could be achieved through analysis of the quantitative and qualitative data monthly to provide an ongoing action plan for the RSI and RRP network of services.

Outcomes	Name of Service:
General	
Referrals received	
No on waiting list	
Entries into service	
Planned exit from service	
Unplanned exit from service (please outline reasons)	
Current on caseload	
Number of contacts	
Outcomes	
Accommodation	
Tenancies sustained	
Tenancies sourced/commenced	
Successful move into SA	
Successful move other (please state destination)	
Family and relationships	
Service commenced contact with family	
Client commenced engagement with family	
Finances	
Referral to financial support	
Commenced budgeting support	
Commenced debt support	
Drugs and alcohol	
Referral to DA service (ext to CGL Outreach)	
Commenced drug treatment (script/meds)	
Commenced drug treatment (Psychosocial support)	
Employment, education, and training	
Commenced education or training programme	
Completed education or training programme	
Commenced voluntary work inc peer support	
Commenced employment	
Health	
New GP registration	
Commenced access to MH support	
Commenced access to physical health support	
Commenced medication	
Commenced other health intervention (please outline)	
Specialist support	
Supported to access DV services	
Supported to report crime	
Supported in relation to sex work	

Summary of other outcomes achieved	
Case study	
What was the situation?	
What actions were taken?	
What were the outcomes?	
What was the impact?	
Feedback quotes	
Feedback/quotes from people supported	
Service feedback	
What is working well?	
What is not working well?	
What needs to happen?	

Table 17: Service Level outcomes monitoring framework.

4.3. Individual outcomes monitoring:

To account for the nuances across RSI and RRP services, and for the varying pathways that people may take through the services, as well as to measure distance travelled, an individual level outcomes monitoring framework is also proposed. It is suggested that the individual outcomes monitoring form is completed on entry into services and every 3 months until exit from services. It is recognised that the completion of such forms can be difficult when working with people experiencing complex needs and therefore there is an option for much of the form (Part one) to be completed by a staff member using professional judgement, when this is not feasible. It should also be noted, that as well as outcomes monitoring, the form can be utilised as a tool for discussion with the person being supported, to aid future action planning.

Within Part one, there is a distance travelled progress measure for practical progress and confidence. The scoring guidance for this is as follows:

Overview	Practical progress	Confidence
1	Not ready to address	No confidence, unsure if can address
2	Talking about difficulties and change but no action taken	Belief that things can change but need assistance to do this
3	Starting progress	Can do some things independently, sometimes need support
4	Continuing progress	Mostly confident to manage independently
5	Managing OK, no issues to address	Confidently managing and knows where to go to get help if any issues arise

Table 18: Scoring guidance for individual outcomes monitoring form.

Please see over the page for the outcomes monitoring proforma. This proforma is for use with clients who are or have been homeless or rough sleeping. An alternative short proforma is provided for use with landlords for the Call B4 You Serve Service, to gain feedback at exit point only.

Proforma 1: Individual outcomes monitoring form

PART ONE (should be completed with client, where possible)
Participant Information

Participant ID/Name	
Date	
Review number	
Completed with client	Y N
Staff name	

Current service access (past 7 days, tick all that apply)

SOT		TVN		LLO	
CGL		CPN		HF	
NPRS (gen)		SOTSW		MCN	
PN		MHN		TSC	

Progress

	Practical progress (1-5)	Confidence (1-5)	Comments
Accommodation			
Mental health and wellbeing			
Physical health			
Drugs and alcohol			
Employment			
Training/education			
Finances			
Family and relationships			
Friends and support networks			
Other skills:			

Summary of progress since last review inc. outcomes achieved			
What's working well			
What's not working well			
What needs to happen			
Client feedback			
If exiting service, please state destination		Expected duration at destination	

PART TWO (validated measures, should always be completed with client)

Wellbeing

Statement	**None of the time**	**Rarely**	**Some of the time**	**Often**	**All of the time**
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

Resilience

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
I tend to bounce back quickly after hard times					
I have hard time making it through stressful events					
It does not take me long to recover from a stressful event					
It is hard for me to snap back when something bad happens					
I usually come through difficult times with little trouble					
I tend to take a long time to get over setbacks in my life					

Social Trust

Generally speaking, would you say most people can be trusted, or you can't be too careful when dealing with people.

Can't be too careful						Most people can be trusted				
0	1	2	3	4	5	6	7	8	9	10

Proforma 2: Landlord Exit Form

To help us continue to support people and ensure quality service, we would be very grateful if you could complete the following questions in relation to the Call B4 You Serve Service

	Strongly disagree	Disagree	Agree	Strongly agree
The service has helped address the issues I had in relation to the tenancy				
The communication from the service has been effective				
I would recommend the service to others				

What impact has the service had on your situation?	
Do you have any suggestions to improve the service?	
Any additional comments?	

5. Conclusion

We were tasked with addressing four key sets of questions:

a. What does the theory and evidence base (nationally and internationally) identify as the critical success factors in supporting those currently or at imminent risk of rough sleeping? What are the outcomes of this support?

This has been comprehensively addressed in both the accompanying literature review and in this report.

b. What are the critical success factors of the Nottinghamshire RSI and RRP interventions and how do these compare to those identified above?

Many of the factors which the literature review indicated as successful nationally and internationally are now being offered in Nottinghamshire, and are proving successful here in reducing rough sleeping and in leading to a range of other good outcomes. These include: street outreach, intensive support, personal budgets, landlord support, the use of navigators, and rapid access to support in relation to mental health and substance use. Some elements were only just becoming embedded in practice as we completed our work. Initial feedback was that newer elements including navigators, social workers embedded in teams and projects; and the use of a Housing First approach are all working well, and we have highlighted in the discussion above and in the separate review how these elements are supported by the national and international evidence.

c. What outcomes are delivered by the Nottinghamshire RSI and RRP interventions and how do these compare to those identified above?

The report has provided detailed evidence of both hard and soft outcomes, illustrating that the projects funded by RSI and RRP are generally working well individually and collectively.

d. Based on the above, recommend a framework of key principles and outcomes that RSI and RRP services should operate under, as well as a methodology to evaluate delivery of these.

The last section of the report provides a detailed and layered set of recommendations for monitoring outcomes, which, if implemented, will provide a robust and comprehensive evaluation of interventions going forward.

We identified a small number of interventions which are both highlighted as successful or promising in the literature and feature in the discussions with participants in Nottinghamshire as gaps or areas for further development, as follows:

1. Family mediation. Busch-Geertsema and Fitzpatick (2008) found that the majority of those accepted as statutorily homeless in England are from newly forming or splitting households (for example, as a result of relationship breakdown between partners or young people being asked to leave the family home), rather than established households losing their existing tenancy or other accommodation. This finding points to the importance of family mediation as an activity to prevent eviction from the parental home, or to facilitate young people's access to family support to assist them with independent living.

2. Domestic violence victim support. This includes a range of interventions such as 'sanctuary schemes' (security measures to enable victims to remain in their own homes after exclusion of the violent partner), supporting planned moves, crisis intervention services and resettlement support (Busch-Geertsema & Fitzpatrick, 2008).

3. Access to meaningful activity, skills training and physical activity are highlighted as facilitators to individuals successfully moving away from homelessness (Reisenberger et al., 2010), and to improving mental health (Marshall et al., 2018). Evidence is building for the place of Social Prescribing (Jagpal et al., 2020) and creative solutions to these issues (Thomas et al., 2011).

6. About the Research team

Jim Rogers

Jim worked for twelve years as a mental health nurse in a range of settings including hospital based mental health wards, detox and rehabilitation units, and community detox and drug and alcohol support teams. During this time, he managed a number of substance misuse projects and agencies, and worked with a wide range of individuals with mental health and substance use problems. One of the projects that he managed, a partnership between the NHS and the third sector was highlighted as a model of best practice by the Social Services Inspectorate for England and Wales. He has also worked in the voluntary sector managing volunteer projects with both young people and older people, and homeless groups. He has conducted in-depth research with people experiencing problem gambling, which involved extensive interviews, and participant and non-participant observation in mutual aid groups. With his blend of clinical and research experience, Jim has a good grounding in how to interview and work with individuals facing challenges such as homelessness. He also understands the needs and pressures of agencies who work in the sector, and the challenges that they face in gathering and collaring data.

Lauren Smith

Prior to joining the University of Lincoln as a Lecturer in Psychology in 2020, Lauren worked voluntary sector services supporting people in the Criminal Justice System for 14 years. Her roles included performance and development of services, delivery of resettlement support services in prisons, development, and delivery of support services for people transitioning from the community into prison, delivery of services to families of people in prison, and work within a supported accommodation provider for families and young people. Her research interests are centred around the rehabilitation and reintegration of people with convictions, including the complex relationships between homelessness, employment, health, and addictions and offending and reoffending. Lauren utilises a variety of qualitative and quantitative methods to undertake her work.

Thomas George

Thomas has been a Research Assistant at the University of Lincoln since 2015 and has been involved in multiple service evaluations. Thomas is an experienced qualitative researcher having worked on the above P3 ACTionLincs Project from its inception. He has established an excellent rapport with participants, link workers and stakeholders which has enabled comprehensive data collection. Thomas was the project lead for conducting participant interviews and collection of questionnaire data, including staff focus groups. Thomas was a keynote speaker at the British Academy Conference at the University of Lincoln in 2019 called 'Representing Homelessness' in July 2019 in which he presented findings on the project. Thomas has authored and co-authored several academic papers on rough sleeping, with several papers in review (George et al., 2020; Rogers et al., 2020). Thomas has also engaged in a YMCA Lincolnshire Sleep Easy charity event raising money for YMCA facilities.

Amanda Roberts

In a previous position, Amanda worked at Kings College London, investigating biological and psychological correlates of various mental illnesses such as Chronic Fatigue Syndrome. It is here that she learned to conduct an extensive clinical interview. Many participants on this project were homeless and she is conscious of the methodological, safeguarding, and ethical concerns that sometimes arise in relation to this specific population. Whilst conducting research at Queen Mary University she was Project Manager for the Prisoner Cohort Study, the principal project commissioned by the Home Office as part of the Dangerous and Severe Personality Disorder (DSPD) programme. Within this project, she conducted lengthy interviews with prisoners, many of whom were vulnerable and also homeless. This work led to several significant papers being submitted to the Home Office which led to the programme being transformed and moved from high security to medium security units and with further support given to vulnerable populations.

7. References:

Adamson, J., Lamb, H., Moreton, R., Robinson, S., & Howe, P. (2015). *Fulfilling Lives: Supporting People With Multiple Needs, Evaluation Report: Year 1* (Leicester: Big Lottery Fund/CFE).

Addorisio, S., Kamel, M. M., Westenberg, J. N., Heyd, A., Maragha, T., Abusamak, M., ... & Krausz, R. M. (2021). Unmet service needs and barriers to care of individuals experiencing absolute homelessness in Edmonton, Canada: a cross-sectional survey. *Social Psychiatry and Psychiatric Epidemiolog*y, 1-9.

Advisory Council on Misuse of Drugs (2019). *Drug-related harms in homeless populations and how they can be reduced.* ACMD.

Alexandrescu, L. (2020) Streets of the 'spice zombies': Dependence and poverty stigma in times of austerity. *Crime, Media, Culture*, *16*(1), 97-113.

Alsuhaibani, R., Smith, D.C., Lowrie, R.,Sumayah,A.,& Paudyal,V. (2021)Scope, quality and inclusivity of international clinical guidelines on mental health and substance abuse in relation to dual diagnosis, social and community outcomes: a systematic review. *BMC Psychiatry 21***,** 209.

Barile, J.P., Smith-Pruitt, A. & Parker, J.L. (2018) A latent class analysis of self-identified reasons for experiencing homelessness: opportunities for prevention. *Journal of Community and Applied Social Psychology, 28* (2), 94-107.

Bernad,R.,Talens,F., Geraci,I., Julián,M., Yuncal,R.,& Ramos,M. (2018). Housing First Elements Facilitating Resilience in Clients with Addictions in the Hábitat Programme: a Qualitative Study. *European Journal of Homelessness, 12*,1,

BMA. (2020) *Impact of COVID-19 (Coronavirus) on homelessness and the private rented sector.* Retrieved from https://www.bma.org.uk/media/3582/bma-submission-impact-of-covid-on-homelessness-and-prs.pdf.

Bommersbach, T. J., Stefanovics, E. A., Rhee, T. G., Tsai, J., & Rosenheck, R. A. (2020). Suicide Attempts and Homelessness: Timing of Attempts Among Recently Homeless, Past Homeless, and Never Homeless Adults. *Psychiatric Services*, *71*(12), 1225-1231.

Buhrich, N., Hodder, T. & Teesson, M. (2000) Lifetime prevalence of trauma among homeless people in Sydney. *Australian and New Zealand Journal of Psychiatry, 34*, 963-966.

Busch-Geertsema, V. & Fitzpatrick, S. (2008) *Effective homelessness prevention? Explaining homelessness reductions in Germany and England.* Retrieved from: https://www.researchgate.net/profile/Volker-Busch-Geertsema/publication/253871464_Effective_Homelessness_Prevention_Explaining_Reductions_in_Homelessness_in_Germany_and_England/links/545824ed0cf2bccc49112014/Effective-Homelessness-Prevention-Explaining-Reductions-in-Homelessness-in-Germany-and-England.pdf.

Centers for Disease Control and Prevention (CDC), 2017. Sleep and sleep disorders: Data and statistics. Retrieved from https://www.cdc.gov/sleep/data_statistics.html

Cherner,R., Aubry,T., Sylvestre,J., Boyd,R., & Pettey,D. (2017) Housing First for Adults with Problematic Substance Use. *Journal of Dual Diagnosis*, *13(*3), 219-229.

Choe, J. Y., Teplin, L. A., & Abram, K. M. (2008) Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. *Psychiatric Services*, *59*(2), 153-164.

Cleary, M., Visentin, D., Thapa, D. K., West, S., Raeburn, T., & Kornhaber, R. (2020). The homeless and their animal companions: An integrative review. *Administration and Policy in Mental Health and Mental Health Services Research*, *47*(1), 47-59.

Cox, R., Lahey, J., Rohades, H., Henwood, B. & Wenzel, S. (2020). Does the timing of incarceration impact the timing and duration of homelessness? Evidence from 'The transitions to housing' study. *Justice Quarterly,* 1-25.

Coohey, C., Easton, S. D., Kong, J., & Bockenste*dt, J. K. W. (2015). Sources of psychological pain and suicidal thoughts among homeless adults. Suicide and Life-Threatening Behavior*, *45*(3), 271–280.

Crisis (2021). Rough sleepers and complex needs. Retrieved from: Rough sleepers and complex needs | Crisis | Together we will end homelessness

Delgadillo, J., Godfrey, C., Gilbody, S., & Payne, S. (2013). Depression, anxiety and comorbid substance use: association patterns in outpatient addictions treatment. *Mental Health and Substance Use*, *6*(1), 59-75.

Ellsworth, J. T. (2019) Spice, vulnerability, and victimization: Synthetic cannabinoids and interpersonal crime victimization among homeless adults. *Substance Abuse*, 1-7.

Farmer, M. (2017) *The importance of strengthening prisoners' family ties to prevent reoffending and reduce intergenerational crime.* Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/642244/farmer-review-report.pdf

Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008) The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. *PLoS Med*, *5*(12), e225.

Fazel, S., Geddes, J. R., & Kushel, M. (2014) The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*, *384*(9953), 1529-1540.

Fedorowicz, S. & Gidlow, C. (2020) *An advanced nurse practitioner embedded within a rough sleeper's unit in Stoke on Trent: a review*. Staffordshire university. Retrieved from: http://www.brighter-futures.org.uk/wp-content/uploads/2020/12/ANP-report_final-1-003.pdf.

Fischer, P. J., & Breakey, W. R. (1991) The epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist*, *46*(11), 1115.

Fletcher, J., Atkin, A., Murphy, N., Newport, L., Ousey, K. & Sandoz, H. (2020) Learning from COVID-19: developing a more efficient tissue viability service. *Wounds UK, 16*(3), 77.81.

Goodwin, N., & Lawton-Smith, S. (2010) Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-term conditions management. *International journal of integrated care*, *10*, e040.

He, Y., O'Flaherty, B., & Rosenheck, R. A. (2010) Is Shared Housing a Way to Reduce Homelessness? The Effect of Household Arrangements on Formerly Homeless People. *Journal of housing economics*, *19*(1), 1–12.

Heerde, J.A., Bailey, J.A., Toumbourou, J. W., Rowland, B. & Catalano, R.F. (2020) Prevalence of homelessness and co-occurring problems. A comparison of young adults in Victoria, Australia, Washington and the United States. *Children and Youth Services Review, 109*.

Homeless Link (2014) *No second night out across England*. London: Homeless Link

Homeless Link (2020) *Supporting people with no recourse to public funds (NRPF) Guidance for homelessness services.* Retrieved from https://www.homeless.org.uk/sites/default/files/site-attachments/Supporting%20people%20with%20NRPF%20July20.pdf.

Homeless Link (2013) *Better Provision for People with Dual Needs.* Retrieved from: https://www.homeless.org.uk/connect/blogs/2013/nov/08/better-provision-for-people-with-dual-needs

Homeless Link (2021) *Homelessness services in 2020: what's the story (Part One)? Everyone In.* Retrieved from:*h*ttps://www.homeless.org.uk/connect/blogs/2021/mar/03/homelessness-services-in-2020-what%E2%80%99s-story-part-one-everyone-in

Homeless Link (2021) *Causes of Homelessness.* Retrieved from: https://www.homeless.org.uk/facts/understanding-homelessness/causes-of-homelessness

Jagpal, P., Saunders, K., Plahe, G., Russell, S., Barnes, N., Lowrie, R, & Paudyal, V. (2020) Research priorities in healthcare of persons experiencing homelessness: outcomes of a national multi- disciplinary stakeholder discussion in the United Kingdom. *International Journal for Equity in Health,19*(86),1100-1106.

Kings Fund. (2020) *Delivering health and care for people who sleep rough: going above and beyond.* Retrieved from https://www.kingsfund.org.uk/publications/delivering-health-care-people-sleep-rough.

Kroulek, A. (2019). *Mental Health Interpreting: 5 Reasons Interpreters Are Important*. Retrieved from: Mental Health Interpreting: 5 Reasons Interpreters Are Important | K International (k-international.com)

Larsen, J., Tew, J., Hamilton, S., Manthorpe, J., Pinfold, V., Szymczynska, P. & Clewett, N. (*2015)* Outcomes from personal budgets in mental health: service users' experiences in three English local authorities. *Journal of Mental Health, 24*(4), 219-225.

Lemieux-Cumberlege, A. & Taylor, E.P. (2019) An exploratory study on the factors affecting the mental health and well-being of frontline workers in homeless services. *Health & Social Care in the Community,* 27, 4, e367-e378.

Local Government Association (2020) Adult Safeguarding and Homelessness*: a briefing on positive practice.* Retrieved from: https://www.local.gov.uk/adult-safeguarding-and-homelessness-briefing-positive-practice

Local Government Association (2020) *Lessons learnt from councils' response to rough sleeping during the COVID-19 pandemic. LGA.* Available at: https://www.local.gov.uk/publications/lessons-learnt-councils-response-rough-sleeping-during-covid-19-pandemic

Lewer, D., Aldridge, R., Menezes, D., Sawyer, C., Zaninotto, P., Dedicoat, C., Ahmed, I., Luchenski, S., Hayward, A., & Story, A. (2019) Health-related quality of life and prevalence of six chronic diseases in homeless and housed people: a cross-sectional study in London and Birmingham, England. *BMJ Open 9,*e025192.

Mackie, P., Johnsen, S., & Wood, J.(2017) *Ending Rough Sleeping. What Works? An International Evidence Review*. Crisis.

McAuley, M. (2020) *Preventing Homelessness and Sustaining Tenancies in the Private Rented Sector: Scoping Project.* Housing Rights. Retrieved from https://www.housingrights.org.uk/sites/default/files/policydocs/Preventing%20Homelessness%20and%20Sustaining%20Tenancies%20in%20the%20PRS.pdf

Maguire, N.J., Johnson, R., Vostanis, P., Keats, H., & Remington, R.E. (2009) *Homelessness and complex trauma: a review of the literature.* University of Southampton.

Marshall, C., Keogh-Lim, D., Koop, M., Barbic, S. & Gewurtz, R. (2020) Meaningful activity and boredom in the transition from homelessness: two narratives. *Canadian Journal of Occupational Therapy*, *87* (4), 253-264.

MEAM. (2018) *Rough sleeping navigators: Learning from MEAM approach and Fulfilling Lives areas.* Retrieved from: http://meam.org.uk/wp-content/uploads/2018/10/Briefing-on-navigators.pdf

Mental Health Foundation (2015). Homelessness and mental health. Retrieved from Homelessness and mental health | Mental Health Foundation

Moore, C. O. (2018). Open Space, Thin Blankets, and Snores: An Examination of Sleep in Young Adults Experiencing Homelessness. Retrieved from: Open Space, Thin Blankets, and Snores: An Examination of Sleep in Young Adults Experiencing Homelessness (spu.edu)

Munthe Kaas, H., Berg, R., & Blaasvær, N. (2018) Effectiveness of interventions to reduce homelessness: a systematic review and meta-analysis. *Campbell Systematic Reviews*, *14*(1), 1-281

NHS England (2019) *Rough sleepers in homeless hotspots to benefit from NHS mental health outreach.* Retrieved from: https://www.england.nhs.uk/2019/10/rough-sleepers-in-homeless-hotspots-to-benefit-from-nhs-mental-health-outreach/

Nilsson, S. F., Nordentoft, M., Fazel, S., & Laursen, T. M. (2020). Homelessness and police-recorded crime victimisation: a nationwide, register-based cohort study. *The Lancet Public Health*, *5*(6), e333-e341.

O'Toole, T. P., Gibbon, J. L., Hanusa, B. H., Freyder, P. J., Conde, A. M., & Fine, M. J. (2004) Self-reported changes in drug and alcohol use after becoming homeless. *American Journal of Public Health*, *94*(5), 830-835.

Padgett, D. K., Henwood, B., Abrams, C., & Drake, R. E. (2008) Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery. *American Journal of Orthopsychiatry*, *78*(3), 333–339.

Patterson, A. A., & Holden, R. R. (2012). Psychache and suicide ideation among men who are homeless: A test of Shneidmans model. *Suicide & Life-Threatening Behavior*, *42*(2), 147.

Pawson, P., Flint, J., Scott, S., Atkinson, R., Bannister, J., McKenzie, C. & Mills, C. (2005) *The Use of Possession Actions and Evictions by Social Landlords*. ODPM.

Perry, J., & Craig, T. K. (2015) Homelessness and mental health. *Trends in Urology & Men's Health, 6*(2),19-21.

Peters,L. Samuel,V.& Hobson,C. (2021) Shining a light on the experiences of staff working with young homeless people: A grounded theory study. *Children and Youth Services Review*, *121.*

Public Health England (2017) *Better care for people with co-occurring mental health and alcohol/drug use* Public Health England.

Queens Nursing Institute (2020) *Dual Diagnosis Learning Brief.* Retrieved from: https://www.qni.org.uk/resources/dual-diagnosis-learning-brief/

Redline, B., Semborski, S., Madden, D. R., Rhoades, H., & Henwood, B. F. (2021). Examining Sleep Disturbance Among Sheltered and Unsheltered Transition Age Youth Experiencing Homelessness. *Medical Care*, *59*, S182-S186.

Rees, S. (2009) *Mental ill health in the adult single homeless population: a review of the literature*. Crisis. Public Health Resource Unit, 2009. Retrieved from: https://www.crisis.org.uk/media/20611/crisis_mental_ill_health_2009.pdf

Reeve, K., Cole, I., Batty, E., Foden, M., Green, S., & Pattison, B. (2016). *Home: no less will do-homeless people's access to the private rented sector*. Project Report. London, UK, Crisis.

Reeve, K., McCarthy, L. Pattison, B., Parr, S., Batty, E., Maye-Banbury, A., Bashir, N., & Dayson, C. (2018) *The mental health needs of Nottingham's homeless population: an exploratory research study Final Report.* Sheffield Hallam University.

Reisenberger, A., Barton, D., Satchwell, C., Wilson, A.,Law, C., & Weave, S. (2010) *Engaging homeless people, Black and Minority Ethnic and other priority groups in Skills for Life*. National Research and development centre for adult literacy and numeracy.

Rogers, J., George, T., & Roberts, A. (2020) Working with individuals who have experienced homelessness: stresses and successes. *Housing, Care and Support, 23*(2).

Roos, L. E., Mota, N., Afifi, T. O., Katz, L. Y., Distasio, J., & Sareen, J. (2013). Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders. *American Journal of Public Health, 103*(S2), S275-S281.

Sachs-Ericsson, N., Wise, E., Debrody, C. P., & Paniucki, H. B. (1999). Health problems and service utilization in the homeless. *Journal of Health Care for the Poor and Underserved*, *10*(4), 443-452.

Sariaslan, A., Arseneault, L., Larsson, H., Lichtenstein, P., & Fazel, S. (2020) Risk of subjection to violence and perpetration of violence in persons with psychiatric disorders in Sweden. *JAMA psychiatry*, *77*(4), 359-367.

Seria Walker, E. (2018) *Evidence review: Adults with complex needs (with a particular focus on street begging and street sleeping).* Public Health England.

Sheikh, S., & Teeman, D. (2018) *A rapid evidence assessment of what works in homelessness services.* Social Care Institute for Excellence.

Social Exclusion Unit. (2002) *Reducing reoffending by ex-prisoners.* Retrieved from https://www.bristol.ac.uk/poverty/downloads/keyofficialdocuments/Reducing%20Reoffending.pdf

Spence, S. A. (2009) Roofless in a steel city: Learning from the homeless mentally ill. *Psychiatric Bulletin*, 33, 64–69.

Spence, S. A., Lee, K. H., Brown, E., David, R., Girgis, S., & Parks, R. W. (2006) Childhood abuse and adult violence in homeless people. *Psychiatry and Clinical Neurosciences,* 60(2), 259.

Stafford, A., & Wood, L. (2017). Tackling health disparities for people who are homeless? Start with social determinants. *International journal of environmental research and public health*, *14*(12), 1535.

Taylor O., Loubiere, S. & Tinlan, A. (2019) Lifetime, 5-year and past-year prevalence of homelessness in Europe: a cross-national survey in eight European nations. *BMJ, 9*.

Taylor, A., Murillo, R., Businelle, M. S., Chen, T. A., Kendzor, D. E., McNeill, L. H., & Reitzel, L. R. (2019) Physical activity and sleep problems in homeless adults. *PloS one*, *14*(7), e0218870.

Thomas, Y., Gray, M., McGinty, S., & Ebringer, S. (2011) Homeless adults engagement in art: First steps towards identity, recovery and social inclusion. *Australian Occupational Therapy Journal*, *58*, 429–436.

Timms, P., & Drife, J. (2021) Mental health services for single homeless people. *BJPsych Advances, 27*(2), 104-114.

Tracy D K, Wood D M, Baumeister D. Novel psychoactive substances: types, mechanisms of action, and effects. *BMJ 2017; 356.*

Turning Point (2016) *Dual Dilemma.* Turning Point. Retrieved from: https://www.turning-point.co.uk/_cache_96dc/content/dual_dilemma-5090910000020596.pdf

Tyler, K.A. & Schmitz, R.M. (2017) Using Cell Phones for Data Collection: Benefits, Outcomes, and Intervention Possibilities with Homeless Youth. *Child Youth Services Review*, *76*, 59-64.

van Laere, I. R., de Wit, M. A., & Klazinga, N. S. (2009) Pathways into homelessness: recently homeless adults problems and service use before and after becoming homeless in Amsterdam. *BMC Public Health, 9*(1), 1-9.

Watson, D.,Shumna,V.,Kowalsky,J.,Golembiewski,E., and Brown,M. (2017) Housing First and harm reduction: a rapid review and document analysis of the US and Canadian open- access literature, *Harm Reduction Journal, 14(1)*

Wilson, W. & Barton, C. (2021) *Rough Sleeping (England)* House of Commons. Retrieved from https://commonslibrary.parliament.uk/research-briefings/sn02007/.

8. Appendices

Appendix 1: Service User Questionnaire

About you

Please write your answer or circle the correct response

Your age (years)		**Your nationality**	
Your gender		**Your ethnicity**	
Do you identify as transgender?	Yes No	**Have you ever served in the Armed Forces?**	Yes No

Which local authority area of Nottinghamshire are you currently staying in? Please tick one

Nottingham City		**Ashfield**	
Bassetlaw		**Gedling**	
Newark and Sherwood		**Broxstowe**	
Mansfield		**Rushcliffe**	

What is your immigration status?

Status	**Tick one**
UK national	
European National (not from the UK)	
Asylum Seeker	
Refugee	
Permanent residence or indefinite leave to remain	
Unknown	
Other (please state)	

Accessing support in Nottinghamshire

Please tell us how much you agree or disagree about the following statements about Nottinghamshire

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**Doesn't apply**
It is easy to find where to get help with things					
When I need help, I usually get it					
Getting support with housing is easy					
Getting support for mental health is easy					
Getting help for physical health is easy					
Getting my medication is easy					
I can see my GP if I need to					
I can see a mental health worker if I need to					
Getting help for drug use is easy					
Getting help for alcohol use is easy					
Getting help to stop smoking is easy					
Getting help to stop gambling is easy					
Getting help with benefits or finances is easy					
Getting help to get work or training is easy					
Getting help for family issues is easy					
If I am feeling isolated or lonely, I know where I can get help					
If I was a victim of crime, I would feel happy to report it to the police.					

Your housing

Which if these options best describes where you are currently sleeping?

Housing situation	Tick one
Rough sleeping	
Staying in a tent	
In a night shelter	
In supported housing/hostel or foyer	
In a refuge, having fled domestic violence	
Sofa surfing with friends/family	
Living with friends/family long term, not sofa surfing	
Squatting	
In a B&B paid for by someone else	
In a B&B paid for by yourself	
Private tenancy	
Council tenancy	
Own home	
Other (please state)	

How long has this been your current housing situation? _____years, _____months

Have you ever, in your lifetime, done any of the following? If yes, please tell us how old you were when this first happened.

Event	Tick all that apply	What age (if applicable)
Slept rough		
Lived in a tent		
Sofa surfed		
Stayed in a night shelter		
Applied to the council as homeless		
Applied to a hostel as homeless		
Stayed in a refuge following domestic violence		
Had a council tenancy		
Lived in supported housing/hostel		
Had your own home		
Lived in care		

Thinking about the most recent time you became homeless, please tell us about the main reasons for this

Reason	Tick all that apply
Parents or carers no longer able or willing to accommodate	
Other relatives or friends no longer able to accommodate	
Non-violent relationship breakdown with partner	
Abuse or domestic violence	
Overcrowded housing	
Eviction or threat of eviction	
Rent or mortgage arrears	
Other debt-related issues	
End of council tenancy	
End of temporary accommodation	
End of private tenancy	
Financial problems caused by benefits reduction or sanction	
Unemployment	
Anti-social behaviour	
Offending behaviour by you	
Offending behaviour towards you	
Mental health problems	

Physical health problems	
Leaving hospital	
Leaving prison	
Leaving care	
Other (please state)	

Which of these have been a reason for you becoming homeless at any time in your life?

Reason	**Tick all that apply**
Parents or carers no longer able or willing to accommodate	
Other relatives or friends no longer able to accommodate	
Non-violent relationship breakdown with partner	
Abuse or domestic violence	
Overcrowded housing	
Eviction or threat of eviction	
Rent or mortgage arrears	
Other debt-related issues	
End of council tenancy	
End of temporary accommodation	
End of private tenancy	
Financial problems caused by benefits reduction or sanction	
Unemployment	
Anti-social behaviour	
Offending behaviour by you	
Offending behaviour towards you	
Mental health problems	
Physical health problems	
Leaving hospital	
Leaving prison	
Leaving care	
Other (please state)	

What housing and homeless services are you accessing? Please tick all that apply

	Accessing now	**Accessed at any time in the past**
Street outreach service		
Mental health navigator		
Prison Navigator		
Substance misuse outreach		
YMCA supported housing		
Call before you serve		
Tissue viability nurse (wound care)		
DASH (decent and safe homes)		
Ist steps accommodation (Action Housing)		
Other (please state name of provider)		

If you have been discharged from hospital in the past 12 months, did you have somewhere to stay after you were discharged? Please tick one

Not been in hospital	
Yes, I had somewhere suitable to go	
I had somewhere to go but it was temporary or unsuitable	
No, I was discharged to the streets	
Other please state:	

If you have been released from prison in the past 12 months, did you have somewhere to stay after you were released? Please tick one

Not been in prison	
Yes, I had somewhere suitable to go	
I had somewhere to go but it was temporary or unsuitable	
No, I was released to the streets	
Other please state:	

In relation to your current housing situation, please tell us:

What is going well	
What is not going well	
What needs to happen	

Is there anything else you would like to tell us about housing and homelessness?

Your physical health

Are you registered with a doctor?

Yes	
No	

If you are not registered with a doctor, why is this? Please tick all the apply

I am banned from my surgery	
It's too far away	
I don't know how to register	
I don't want to	
I have a fear of the doctor	
Other (please state):	

Are you registered with a dentist?

Yes	
No	

If you are not registered with a dentist, why is this? Please tick all that apply

I am banned from my surgery	
It's too far away	
I don't know how to register	
There is a waiting list	
I don't want to	
I have a fear of the dentist	
Other (please state):	

Has a doctor or health professional ever told you that you have any of the following health problems? Please tick all that apply

Health problem	Yes and I am still experiencing this	Yes, in the past but it is sorted	No, never
Heart problems			
Breathing problems			
Asthma			
Cancer			
High blood pressure			
Joint aches or problems with bones/muscles			
Difficulty seeing/eye problems			
Skin/wound infection problems			

Problems with feet			
Fainting/blackouts			
Urinary problems, infections or incontinence			
Circulation problems or blood clots			
Liver problems			
Stomach problems including ulcers			
Dental problems			
Diabetes			
Epilepsy or seizures			
HIV			
Hepatitis			
Tuberculosis			
Other (please state)			

If you answered yes to any of the above, are you receiving support or treatment? Please tick all that apply

Yes, I'm receiving treatment for all	
I'm receiving treatment for some but not others	
No, but it would help me	
No, I don't need it	
No, I don't want it	
I have been offered help but didn't want it	
I have not been offered help	

Have you spent any time in hospital for a physical health problem in the past 12 months?

Yes	
No	

Has there been any time during the past 12 months when you think you needed a medical examination for a physical health problem, but you didn't get one?

Yes	
No	

If yes, why was this?

Reason	Please tick all that apply
Couldn't get an appointment	
Not registered with service	
Barred from service	
Too far	
No transport to go	
Didn't want to	
Fear of doctors, dentist, hospitals	

Are you on medication for a physical health problem? Please tick

Yes	
No, but I should be	
No	
If yes, What medication?	

Do you have any current concerning symptoms that you are not getting support for?

Yes	
No	

If yes, what are these? _____

Do you smoke cigarettes, cigars or a pipe?

Yes	
No	

If yes, would you like to give up smoking?

Yes	
No	

Have you ever been offered help to stop smoking?

Yes, and took this up	
Yes, but did not take this up	
No	

Have you had a sexual health check in the past 12 months?

Yes	
No	

Do you know where to access free contraception?

Yes	
No	

Do you know where to access advice about sexual health?

Yes	
No	

Have you engaged in sex work?

Yes, currently	
Yes, in the past 12months	
Yes, but not in the past 12 months	
No, never	

Females over 25 only: Have you had a cervical smear test in the past 3 years?

Yes	
No	

Females over 50 only: Have you had a breast examination/mammogram in the past 3 years?

Yes	
No	

Your mental health

Has a doctor or health professional ever told you that you have any of the following mental health or developmental conditions? Tick all that apply

Condition	Yes, and this affects me currently	Yes, but this is not affecting me currently	No, never
Depression			
Anxiety			
Bipolar disorder			
Psychosis (not drug induced)			
Psychosis (drug induced)			
Personality disorder (PD)			
Schizophrenia			
Phobias			
Obsessive compulsive disorder (OCD)			

Post-traumatic stress disorder (PTSD)			
Eating disorder			
Dual Diagnosis (mental health problem and drug or alcohol use			
ADHD			
Learning disability or difficulty			
Autism or Asperger's (ASD)			
Other (please state)			

If you answered yes to any of the above, are you receiving support or treatment? Please tick all that apply

Yes, I'm receiving treatment for all	
I'm receiving treatment for some but not others	
No, but it would help me	
No, I don't need it	
No, I don't want it	
I have been offered help but didn't want it	
I have not been offered help	

If you are receiving mental health support what is this? Please tick all that apply

Medication that is prescribed for me	
Talking to a professional like a counsellor, mental health nurse or therapist	
A service that helps me with mental health and drug or alcohol use at the same time	
Activities like arts, volunteering or sport	
Practical support that helps me live my day-to-day life	
Training and activities to help me learn new skills or gain employment	
Peer support – support from people who have been through a similar experience to me	

Are you on medication for a mental health problem? Please tick

Yes	
No, but I should be	
No	
If yes, what medication?	

Is there any time during the past 12 months when you think you needed support for a mental health problem, but you didn't get it?

Yes	
No	

If yes, why was this?

Reason	Please tick all that apply
Couldn't get an appointment	
Not registered with service	
Barred from service	
Too far	
No transport to go	
Didn't want to	
Fear of doctors, hospitals	
Fear of talking about problem	
Other (please state):	

Have you spent any time in hospital due to a mental health issue? Tick all that apply

Yes, in the past 12 months	

Yes, but not in the past 12 months	
Yes, voluntarily	
Yes, I was sectioned	
No, never	

Have you self-harmed? Please tick one

Yes, self-harmed in the past 12 months	
Yes, self-harmed but longer than 12 months ago	
Had thoughts of self-harm but never done anything	
No self-harm	

Have you ever attempted suicide? Please tick one

Yes, attempted suicide in the past 12 months	
Yes, attempted suicide but longer than 12 months ago	
Had thoughts of suicide but never done anything	
No thoughts of suicide	

Staying healthy: please tick all that apply.

Mobility	**I have no problems walking about**	
	I have some problems walking about	
	I am confined to bed	
Self-care	**I have no problems with self-care**	
	I have some problems with washing or dressing myself	
	I am unable to wash or dress myself	
Usual activities	**I have no problems with performing my usual activities**	
	I have some problems performing my usual activities	
	I am unable to perform my usual activities	
Pain / discomfort	**I have no pain or discomfort**	
	I have moderate pain or discomfort	
	I have extreme pain or discomfort	
Anxiety/depression	**I am not anxious or depressed**	
	I am moderately anxious or depressed	
	I am extremely anxious or depressed	

On a scale of 0-100, with 0 being the worst state you can imagine, and 100 being the best state you can imagine, where would you say your health is?

0_____**25**_____**50**_____**75**__________**100**

Compared to 12 months ago, how would you say your health is now? Please tick one.

My health is better than it was 12 months ago	
My health is about the same as it was 12 months ago	
My health is worse than it was 12 months ago	

Is there anything else you would like to tell us about your health?

Drug and alcohol use

Have you taken any of the following? Tick all that apply

Drug	yes, in the past 12 months	yes, but not in the last 12 months	No, never
Heroin			
Crack			
Cocaine			
Ecstasy			
Ketamine			
Amphetamines/speed			
LSD			
Tranquilisers e.g., benzodiazepines/benzos not prescribed for you			
Any other prescription drugs that were no prescribed for you			
Novel Psychoactive substances (e.g., mamba, spice)			
IV drugs (drugs you inject)			
Other (please state):			

Drug Use Disorder Identification Test (DUDIT)					
Select one box that best describes your answer to each question.					
Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you use drugs other than alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. Do you use more than one type of drug on the same occasion?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
3. How many times do you take drugs on a typical day when you use drugs?	0	1 or 2	3 or 4	5 or 6	7 or more
4. How often are you heavily influenced by drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. Over the past year ?? that you have not been able to stop taking drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often over the past year have you taken drugs and then not done something you should have done?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. How often over the past year have you had guilty feelings or a bad conscience because you used drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10. Have you or anyone else been mentally/physically hurt because you used drugs?	No		Yes, but not in the last year		Yes, during the last year

11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	No		Yes, but not in the last year		Yes, during the last year

Do you take Methadone, Subutex or any other substitute drugs? Please tick

Yes, it is prescribed for me	
Yes, but it is not prescribed for me	
No	

Alcohol Use and Disorders Test (AUDIT)					
Your answers will remain confidential so please be honest. Select one box that best describes your answer to each question.					
Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 time a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six more drinks on one almost occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Do you currently receive any help for your drug or alcohol use? Please tick

Yes	
No, but I want it	
No, I don't want it	
No, I don't need it	

If you are receiving treatment for drug or alcohol use, what is this? Please tick all that apply

	For drug use	For alcohol use
Advice and information (from GP, A&E)		
Harm reduction such as needle exchange		
Peer support groups (e.g., alcoholics anonymous, narcotics anonymous, SMART Recovery)		
Script		
Counselling or psychological support		
Detox		
Residential rehab		
Help from a specialist drug and alcohol support service (e.g., Nottingham Recovery Network, Change Grow Live)		
Access to activities such as art groups, volunteering		
Peer support (support from others who have been through a similar experience)		
Other (please state):		

Gambling

	Never	Sometimes	Most of the time	Almost always
How often have you bet more than you could afford to lose?				
How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?				
When gambling, do you go back another day to try to win back the money you lost?				
How often have you borrowed money or sold anything to get money to gamble?				
Have you felt that you might have a problem with gambling?				
Does/has gambling cause(d) you any health problems, including stress or anxiety?				
How often have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?				
Does/has your gambling cause(d) any financial problems for you or your household?				
How often have you felt guilty about the way you gamble or what happens when you gamble?				

Use of emergency services

Have you used an ambulance, attended A&E, or been admitted to hospital for any of the following in the past 12 months? Tick all that apply.

	Used ambulance	Attended A&E	Been admitted to hospital	None
Domestic violence				
Other violent incident				
Accident				
Due to physical illness				
Due to mental illness				
Self-harm				
Attempted suicide				
Due to drug use				
Due to alcohol use				
Due to childbirth/pregnancy				
Other (please state):				

Your finances

Do you have recourse to public funds (entitled to welfare benefits)? Please tick one

Yes	
No	
Don't know	

Have you had your benefits sanctioned? Please tick one

Yes, currently	
Yes, in the past 12 months	
Not in the past 12 months / never	

What is your current main source of income? Please tick all that apply

No income	
Universal credit	
ESA	
PIP	
Employment	
Crime	
Friends and family	
Pension	
Other (please state):	

Do you have any debts? Please tick one

No debts	
Yes and I am paying all of them	
Yes and I am paying some of them	
I don't know	

If you have debts, approximately how much do you owe? £_____

What type of debts do you have? Tick all that apply

Rent arrears	
Mortgage arrears	
Drug debt	
Borrowed from friend or family	
Bank loan	
Court fines	
Other loan	
Other please state:	

Are you getting any help for your debts? Tick all that apply

Yes, I am being supported	
No but I should be	
No, I don't need it	
No, I don't want it	
No, because I don't know where to go	
No, because I can't get an appointment	
No, I'm barred from the service	

Is there anything else you would like to tell us about debts and finances?

Your family

Do you have contact with your family? Tick all that apply

Yes, I have contact with my family and they support me	
I have contact with my family but they do not support me	
I have contact with some but there are others I'd like to have contact with	
I know where my family live but I do not speak to them	
I do not know where my family are	
I do not have any family	
I would like to have support to contact my family	

Do you have any children under 16?

Yes	
No	
Don't know	

If you have children under 16, which of the following applies?

They live with me	
I have regular contact with them but they do not live with me	
I am allowed to have contact with them but I do not	
I am not allowed to have contact with them	
I do not know where there are	
Children's Services are involved with my children	

Do you have any other caring responsibilities? Please tick

Yes, if so who do you care for: _____	
No	

Is there anything else you would like to tell us about your family?

Your employment and training

Which if the following best describes your current situation? Tick all that apply

I am not doing any work or training	
I am in paid work	
I am doing voluntary work	
I am doing some education or training	
I would like help to get work	
I would like help to get training	
Someone is helping me to get training	
Someone is helping me to get work	
I am retired	

If you have previously had a job but lost it, what was the main reason for this? Tick all that apply

Made redundant	
End of contract	
Got sacked	
Due to committing a crime or going to prison	
Due to homelessness	
Due to drug or alcohol use	
Other, please state:	

Is there anything else you would like to tell us about employment and training?

Experience of crime

Please tell us if you have experienced the following

Experience	Yes, in the last 12 months	Yes but not in the last 12 months	Never
I have been a victim of a non-violent or non-sexual crime (e.g. theft)			
I have been a victim of a violent but non-sexual crime			
I have been the victim of a sexual crime			
I have been the victim of bullying			
I have been a victim of trafficking			
I have been a victim of cuckooing			
I have been a victim of slavery			
I have been a victim of domestic abuse			
I have been a victim of a different type of crime Please state:			
I have reported a crime to the police			
I have received health treatment following a crime			
Other experience of crime (please state):			

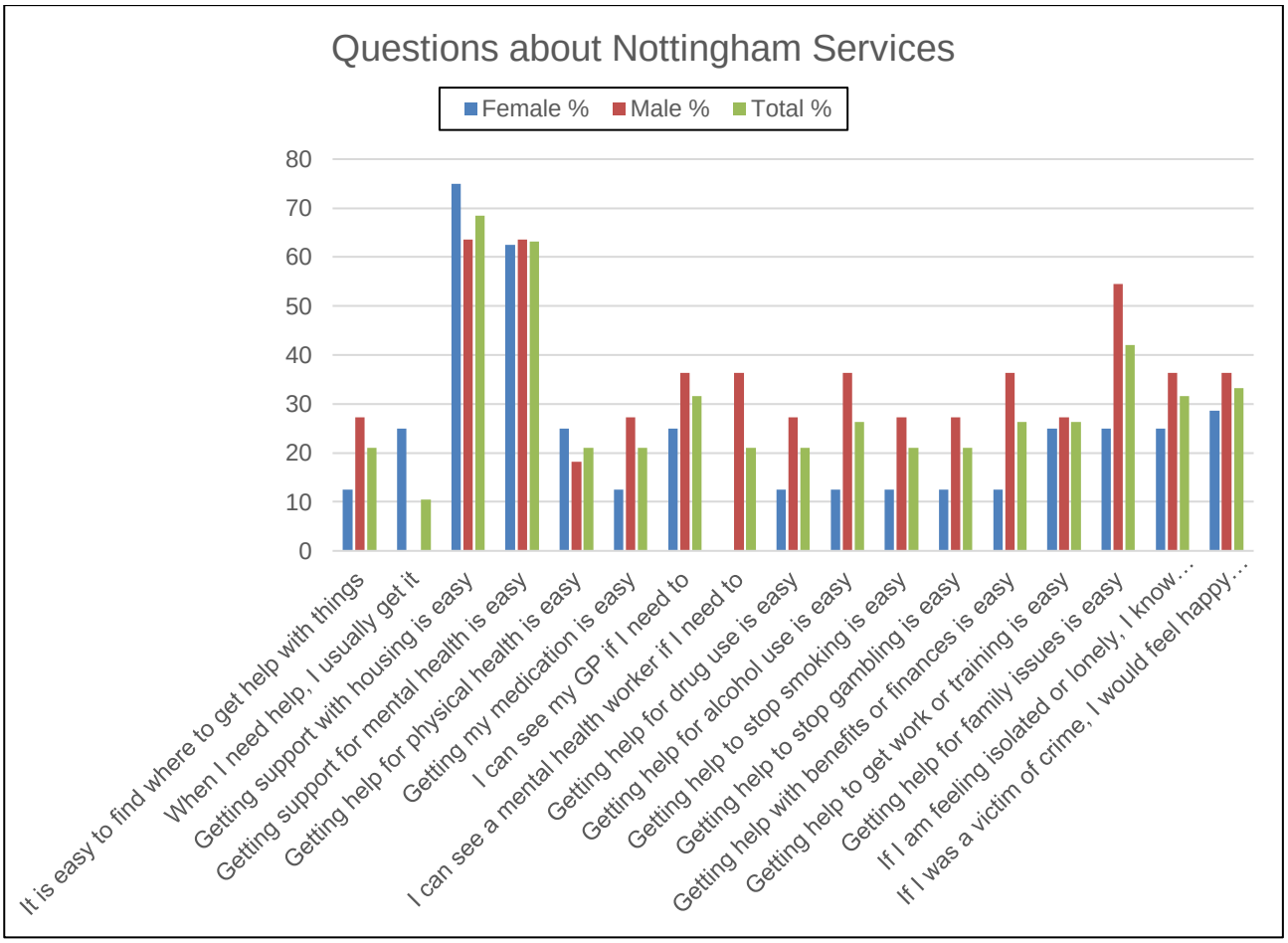
Contact with the criminal justice system

Please tell us if any of these things have happened

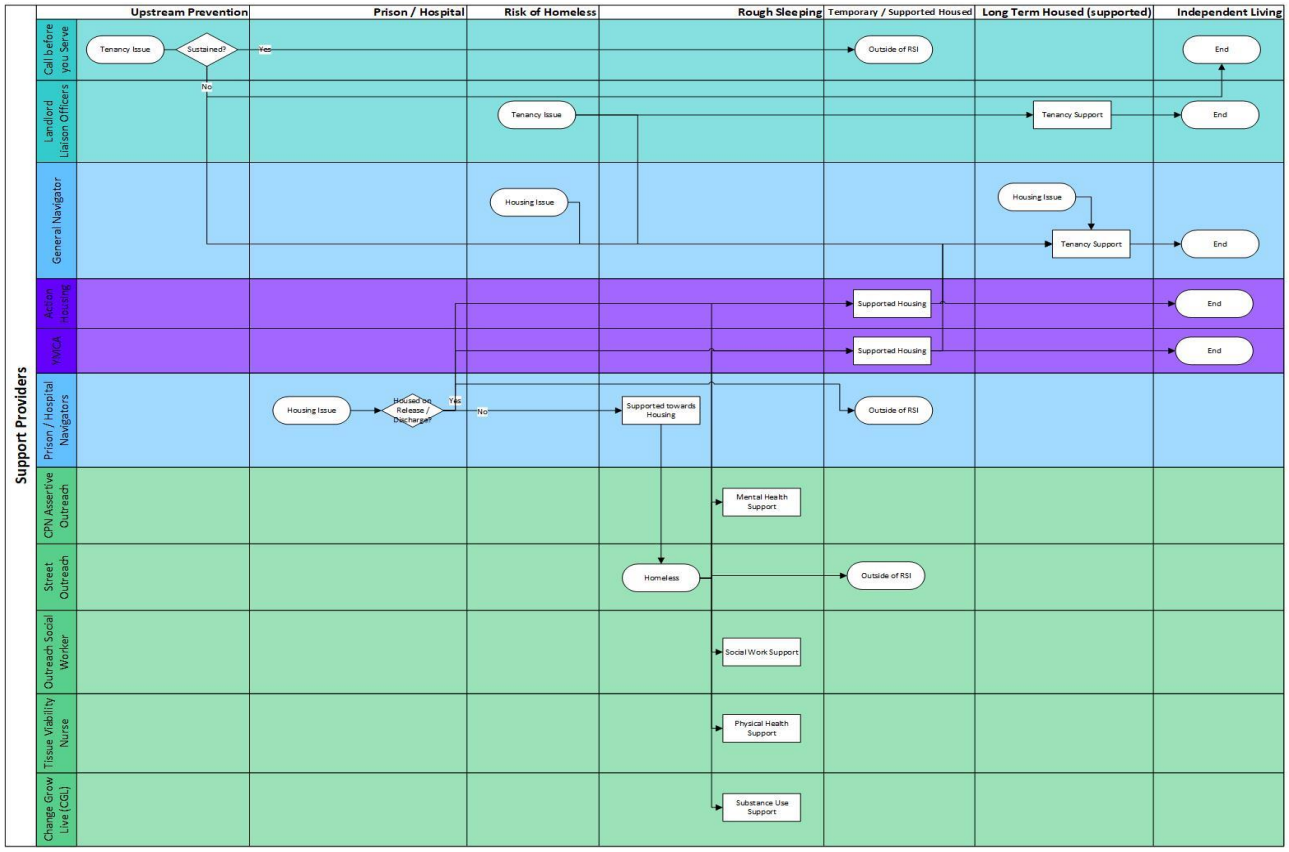
Type of contact	Yes, in the last 12 months	Yes but not in the last 12 months	Never
I have committed a crime			
I have been arrested			
I have been to court			
I have been in prison			
I have been on probation			
I have been given a court fine			
I have been on unpaid work			
I have breached a probation licence			

Is there anything else you would like to tell us?

Appendix 2: ***Figure 11: Service user views on accessing support.***



Appendix 3 Figure 1 RSI and RRP Support Pathways


Support Providers
Upstream Prevention
Prison / Hospital
Risk of Homeless
Rough Sleeping
Temporary / Supported Housed
Long Term Housed (supported)
Independent Living
Call before you Serve
Landlord Liaison Officers
General Navigator
Action Housing
YMCA
Prison / Hospital Navigators
CPN Assertive Outreach
Street Outreach
Outreach Social Worker
Tissue Viability Nurse
Change Grow Live (CGL)
Tenancy Issue
Sustained?
Yes
No
Outside of RSI
End
Tenancy Issue
Tenancy Support
End
Housing Issue
Housing Issue
Tenancy Support
End
Supported Housing
End
Supported Housing
End
Housing Issue
Housed on Release / Discharge?
Yes
No
Supported towards Housing
Outside of RSI
Mental Health Support
Homeless
Outside of RSI
Social Work Support
Physical Health Support
Substance Use Support