The University of Nottingham

Fulfilling Lives
South East Partnership

opportunity NOTTINGHAM
Believing in people. Inspiring change.

Hard to Reach?

The use of one-to-one psychotherapeutic interventions for people experiencing Severe and Multiple Disadvantage: An evaluation of two regional pilot projects.

Authors: Dr David Murphy (Associate Professor, University of Nottingham),
Grant Everitt (Learning and Evaluation Lead, Opportunity Nottingham),
Kerry Dowding (Research and Evaluation Officer, Fulfilling Lives South East),
Anna Tickle (Clinical Psychologist, Framework and Opportunity Nottingham).

November 2020

This is a collaborative piece between Nottingham University, Opportunity Nottingham and Fulfilling Lives South East.
The Fulfilling Lives Programme is funded by the National Lottery Community Fund.

www.opportunitynottingham.co.uk
0115 850 4128
www.bht.org.uk/fulfilling-lives

COMMUNITY FUND

Acknowledgements

We would like to thank the practitioners and beneficiaries at Fulfilling Lives South East Partnership and Opportunity Nottingham who shared their thoughts and experiences to make this evaluation report possible.

We would also like to thank the staff and beneficiaries at Fulfilling Lives Islington and Camden (FLIC), whose insight and support helped to shape the evaluation. Along with Fulfilling Lives South East and Opportunity Nottingham, FLIC was originally part of a Community of Practice concerned with psychological interventions for people experiencing multiple disadvantage, that initiated and funded this study. Particularly we would like to thank Joanne Sherlock, Research Lead at FLIC, who contributed many hours of work that went towards making this report possible.

Contents

1. Executive summary

Context

The term 'Severe and Multiple Disadvantage' (SMD) refers to people who experience a combination of homelessness, mental health difficulties, alcohol or substance misuse and offending. Whilst there has been a recognition of the challenges faced by people with SMD for some time, their needs continue to be inadequately met by systems and services, and they continue to experience a range of negative outcomes.

One way of thinking about SMD is through the lens of compound and cyclical trauma. People who have complex trauma histories are more likely to experience disadvantages such as homelessness, which in turn may contribute to further traumatic events and use of substances to manage overwhelming emotional and psychological challenges. The literature suggests a way to interrupt these cycles is to provide psychotherapeutic support which is person-centred and culturally appropriate. Where appropriate psychotherapeutic interventions have taken place with this group, outcomes have improved. However, people who have experience SMD are often excluded from statutory mental health services due to behavioural presentation and substance use.

The research therefore seeks to find out:

1. **Does accessing an embedded psychotherapeutic intervention for beneficiaries facing severe and multiple disadvantage lead to higher functioning, lower needs and improve level of demand on services compared to support as usual?**
2. **How do severely and multiply disadvantaged beneficiaries of services experience embedded psychotherapeutic interventions?**

The Research

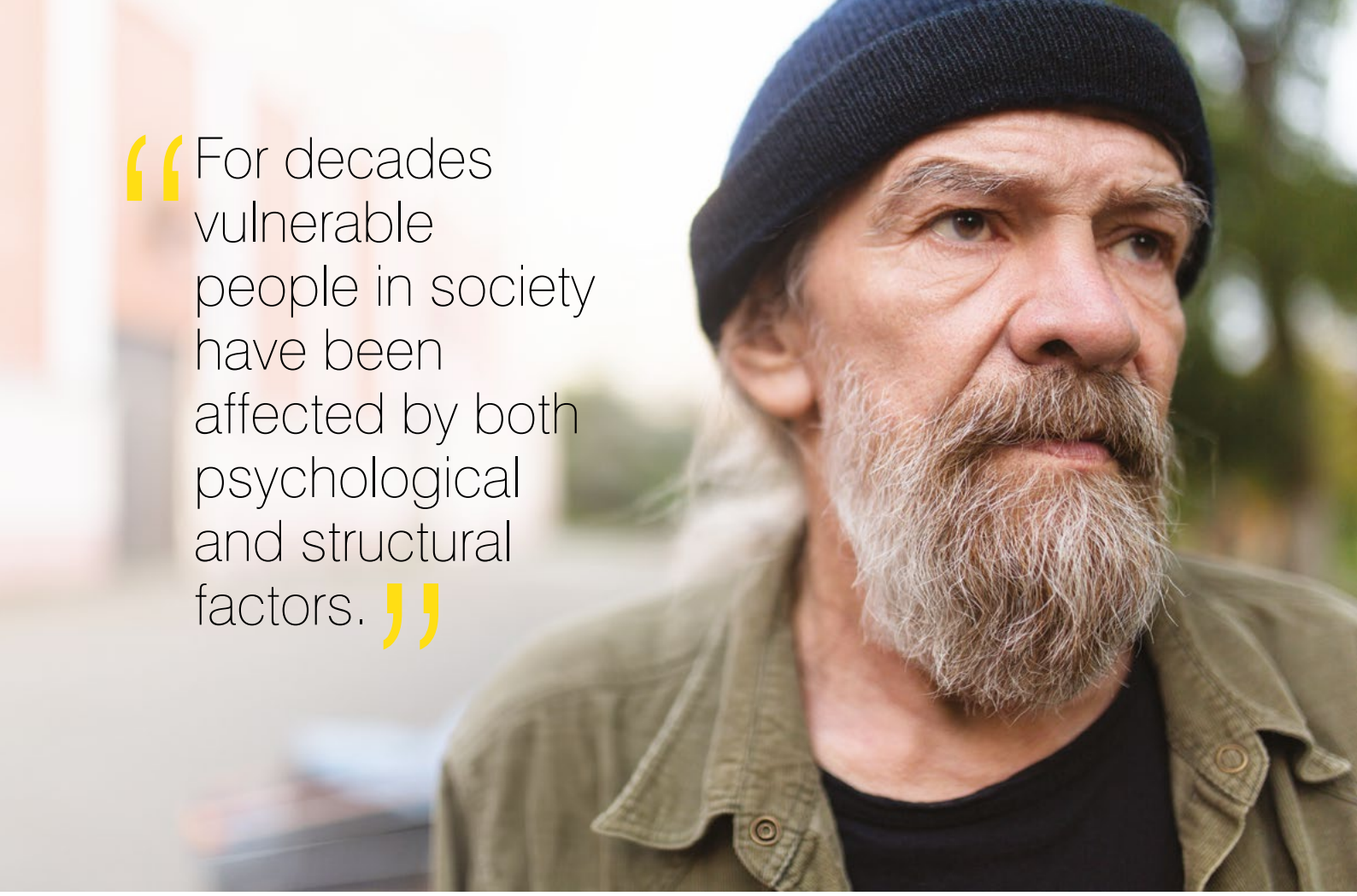
The report shares the findings from two pilot projects which aimed to work psychologically with people accessing SMD specific services. Quantitative data was used to investigate the first research question, and qualitative methods were used to investigate the second. Data was gathered from 289 participants, 26 of whom engaged with the embedded psychotherapeutic intervention that was available. Participants completed self-report surveys at 3-month intervals and took part in semi-structured interviews about their experiences of psychotherapeutic interventions.

Key Findings

- Control and psychotherapeutic intervention groups both showed significant improvement over time
- Those who received psychotherapeutic interventions showed more improvement than control groups on the Homeless Outcome Star and New Directions Team (NDT) measure scores, but these differences were not statistically significant
- Those who received psychotherapeutic interventions had significantly more positive contacts with other services than the control group. Similarly, the control group had significantly higher negative contacts with other services.
- Those who received psychotherapeutic interventions stayed engaged with the project's support service significantly longer than those who did not get this intervention.
- All interviewees valued the psychotherapeutic intervention and felt their mental health had improved as a result of it. Central themes emerging from the interviews were that workers were valued when they were persistent, flexible, genuine and person-centred.

Conclusions

The research adds to growing body of evidence that psychotherapeutic interventions can improve outcomes for people who experience SMD. Reduced negative service use in the intervention group is particularly noteworthy for future commissioning practices, alongside improved engagement in support for those who received the intervention. Qualitative findings support previous literature's assertations that interventions should be person-centred, flexible and focus on building trust. Interventions should also seek to be distinct from previous, typically institutional experiences of mental health support which were experienced by people who are severe and multiply disadvantaged.



> “For decades vulnerable people in society have been affected by both psychological and structural factors.”

2. Introduction

The term ‘Severe and Multiple Disadvantage’ (SMD) defines the needs of a specific group of people in society who experience a combination of homelessness, mental health difficulties, alcohol or substance misuse and offending, or risk of offending. This is not a new phenomenon (Dennis et al, 1991). For decades vulnerable people in society have been affected by both psychological and structural factors that lead them into precarious situations resulting in homelessness, poor mental health, drug/alcohol problems and offending. Some policy makers and service professionals have long considered how best to address the issues and determine what to do to help and support people experiencing SMD (Fischer et al, 1991). Almost forty years ago the classic text produced by two American anthropologists, Ellen Baxter and Kim Hopper (1982), reported on the plight of homeless people with poor mental health. Their graphic descriptions of distressed individuals on the streets of New York in the 1970s and early 1980s demanded the need for integrated services, calling on government policies to bring together public services and (charitable/voluntary) non-governmental organisations to meet the needs of this vulnerable group. The recognition of the unique and complementary strengths of both public/statutory and third sector organisations has long been understood as the way forward for addressing the needs of these vulnerable people.

The number of people experiencing the overlapping of homeless, mental distress and, drug or alcohol problems is increasing: the Lankelly Chase Foundation report *Hard Edges: Mapping severe and multiple disadvantage* (Bramley & Fitzpatrick et al, 2015) suggests that those experiencing homelessness, substance misuse and involved with criminal justice systems in England, reaches around 58,000 people in any one year and this number increases to over a quarter of a million when facing just two of these three problems. In their report, they suggest that SMD is unique from other forms of exclusion due to the degree of stigma attached to, directed at, or experienced by people in this group. Those people, according to the report, are most likely to be white men aged 25-44, who have experienced significant childhood trauma, that has its roots in family and

educational experiences. People experiencing SMD were reported as experiencing much worse quality of life ratings than those not in this group and were spread across England but were particularly found to be in higher concentration in Northern cities, inner London boroughs and seaside towns. Whilst the data is difficult to use with precision to gain an idea of the degree of overlap in forms of disadvantage, it was reported by Bramley et al (2015) that interventions working with these groups show some short-term improvements but these were weaker amongst those with the most complex problems. These findings are particularly important as they reflect the high levels of overlapping drug and alcohol problems with poor mental health in the homeless population reported in the US by Fischer et al (1991) some 30 years ago. Given the length of time since these issues were first highlighted in academic literature, it would seem that, our social and political systems have done little to prevent such problems arising for people and that there is much work still to be done to prevent the development of SMD.

A more recent report, *Gender Matters* (Sosenko, Bramley, & Johnsen, 2020) takes a closer look at the issues specifically relating to women experiencing SMD, but also uncovers some more nuanced and detailed analysis of hidden groups of men, and hidden BAME groups. In the *Hard Edges* report, SMD was defined by using involvement in the criminal justice system as a form or disadvantage; this led to the identification of a greater number of men than women, meaning that many women who experience disadvantage, but were not the perpetrators of crime, were hidden from the data. However, they might be the victims of crime. In the *Gender Matters* report, the definition used for SMD included violence and abuse within the home. When the new definition is used, then women are at least as equally represented as experiencing disadvantage as men, and the overall figures rise to 336,000 people (in England) affected.

Given that SMD is a growing problem in the UK, it is encouraging that a significant initiative was launched through the National Lottery Community Fund in the form of the Fulfilling Lives Programme. Fulfilling Lives aims to support people with longstanding difficulties who are not engaging with existing services. Twelve Partnerships (projects) were established across the UK and each has its own unique arrangement for addressing the main aims in response to local needs; developing a way of working that is in collaboration with their local agencies, ensuring service beneficiaries are placed at the centre of their project. Whilst the Fulfilling Lives Project is being evaluated as a whole, further details about the project can be found here (https://www.fulfillinglivesevaluation.org/about/initiative/). The aim of this report is to focus on an evaluation of a specific aspect of the Programme in Nottingham and the South East.

This document reports on the evaluation of psychotherapeutic interventions developed by two pilot projects aimed at working with the SMD population in the partnership. Each project has employed a member of staff that has been dedicated to engaging and working psychotherapeutically with people accessing their services. To qualify for the services of the projects, a person must be experiencing at least three of the four areas of multiple disadvantage. The next section of the report provides a description of each of the projects. Following this, there is a literature review that considers what is known from prior studies that have focused on psychotherapeutic interventions, for people facing multiple disadvantage. Next, we set out the methodology used to carry out this evaluation which is followed by a presentation of the quantitative and qualitative data that has been collected and analysed. Finally, we have considered these findings and then provide some recommendations for further work and potential implications for practitioners in this field.

3. Background and context

The two projects included in this evaluation are Opportunity Nottingham and Fulfilling Lives South East Partnership. They are both part of the 'Fulfilling Lives: Supporting people experiencing multiple disadvantage' programme. Multiple disadvantage in the context of the programme refers to experiencing at least three of the four criteria of homelessness, poor mental health, substance misuse and offending. The programme commenced in 2014 and is funded by the National Lottery Community Fund. It is described on their website as "a £112 million investment over 8 years supporting people who are experiencing multiple disadvantage. The programme funds local partnerships in 12 areas across England to test new ways of ensuring individuals receive joined up and person-centred services which work for them[1]."

All projects on the programme have similar aims and outcomes. Opportunity Nottingham's aims are:

1. Empowering people with multiple and complex needs. Enabling them to take control of their lives.

2. Changing the front-line service approach. Improving coordination. Increasing Beneficiary input. Agreeing realistic timescales.

3. Changing the system's DNA. Using project findings to make the case for change at a strategic and commissioning level.

Whilst Fulfilling Lives South East Partnership has the following outcomes:

1. People with multiple and complex needs, previously not engaging well with services, self-report that they are better able to manage their lives, as a result of services being more accessible, targeted and better coordinated.

2. Service users are empowered to directly influence service design and delivery within the project and externally.

3. Services and roles will better meet the needs of service users through undergoing a process of review and evaluation, leading to lasting change in design and delivery.

4. Long term improvements in systems, commissioning and policy will be achieved through shared learning and strengthened outcomes evaluation.

Consequently, both projects carry out a similar range of activities. This includes client-facing delivery, changing systems to improve services used by people who experience multiple disadvantage, involvement of lived experience and creating an evaluation and learning legacy.

Where projects differ is in the balance of these activities and how they deliver them. Opportunity Nottingham has focused more resource in the direct delivery of support to individuals, and as a result has supported more people. Fulfilling Lives South East Partnership has more non client facing staff working with services directly to facilitate system change. There was no programme requirement to employ staff specifically working on psychotherapeutic interventions, but both projects independently considered it a good use of funds to develop such a role, as part of their front facing delivery service.

[1] https://www.tnlcommunityfund.org.uk/funding/strategic-investments/multiple needs#:~:text=The%20Fulfilling%20Lives%20programme%20is,services%20which%20work%20for%20them.

4. Literature review

A big problem: from the global to the local

There should be no doubt about the scale of the issue that governments around the world are facing in regards to responding to the need of people experiencing SMD. In England, the problem is significant, affecting tens of thousands of people each year (Bramley et al., 2015). The situation is similarly problematic in the USA (Bassuk & Buckner, 1992), Australia (Banfield & Forbes, 2018), New Zealand (Whiteford, Buckingham, Harris et al., 2017), and West Africa (Nigeria, Côte d'Ivoire and Bénin) (Eaton, Des Roches, Nwaubani, et al., 2015), to name just a few countries where researchers have recently reported on programmes aimed at addressing the problem of SMD.

> "For decades there have been calls for system change."

The need to design effective services and, the systems in which they exist, to address the needs of people facing severe and multiple disadvantage has not been satisfied. For decades there have been calls for system change in the way that those that experience SMD are supported. In the early 1990s, shortly after the shift towards care for mentally distressed people in the community, there was an increase in the recognition of the issue of mentally distressed people and homelessness. In the USA, for example, Bassuk and Buckner (1992) called for systems change following a report they believed did little more than try to put the homeless mentally ill 'out of mind - out of sight'. More recently, there have been attempts to adopt more person-centred care approaches, where people are helped by being understood 'in context' and responded to with a 'care coordination' approach. Care coordination draws support for people from a range of different service sectors, physical

health, mental health, housing, probation, attempting to provide care across the professional boundaries and can include family, professionals, third sector organisations and community services. The overall aim is intended to bring better health and well-being for people through a joined-up system of coordinated care, with a single person responsible for holding all the threads connecting each aspect of the care available and also supporting navigation of and access to relevant services.

Despite its popularity for a number of years, the care coordination approach lacks a broad empirical evidence base. Some research has looked at this way of working such as Banfield and Forbes (2018) who evaluated an Australian project called the Partners in Recovery Programme (PRI). The PIR programme looked at the effectiveness of the care coordination approach for people with complex mental health problems, many of whom meet the criteria for SMD. Through a combination of qualitative and quantitative methods they found that service users were satisfied with the programme overall, and that access to support improved. Nevertheless, they concluded that service users perceived that their project's success to have been limited due to communication difficulties. One important feature of their findings was that the person who acted as the care coordinator were considered to be a central figure in the impact the programme had for users.

In three West African countries, Nigeria, Côte d'Ivoire and Bénin two main systems of support for homeless people with mental health problems and other complex needs have been developed. In a short report on two approaches, a number of helpful aspects were identified. First, there was a focus on the involvement of residents' participation in jointly developing community life. Second, there were different approaches to responding to mental health needs. One service offered counselling to residents and the other provided access to a mental health nurse. An important aspect of development was the opportunity to learn skills and engage in work possibly through an apprenticeship style arrangement. Third, it was concluded that these kinds of services for people with SMD are most likely to work best when they are rooted deeply within the established and local structures so they lead to comprehensive social inclusion as a main outcome.

Even from this brief review of studies from different countries across the world, it can be seen that what is important to people experiencing SMD is, first, that it is the people they encounter as the provider of their support that really matters and, second, that services embedded within communities are accessible and of more benefit. That is, the quality of connection and relationship between someone experiencing SMD and the person that is trying to help them, is incredibly important (Sandu, 2019) and, that this relational work takes place in a setting that is culturally appropriate to the end user. This seems to be the case whether the target population are Aboriginal Australian women (Lee, Harrison, Mills, & Conigrave, 2014), the people experiencing homelessness and mental illness in West Africa or, people accessing care across both statutory and third sector provisions in Australia (Harvey, Brophy, Parsons, Moeller-Saxone, Grigg, & Siskind, 2016).

A promising and recent development in the field of SMD is the recognition of the links between homelessness, poor mental health, substance misuse and offending through an appreciation of the cycle of trauma often experienced by these groups. For people who are traumatised this can result experience SMD, but also the experience of homelessness or hospitalisation, due to poor mental health or involvement in the criminal justice system, can in themselves be traumatic experiences. Because of the presence of these experiences, people might often cope through drug or alcohol use and this in turn might lead to further disadvantage or possibly precede multiple disadvantage. Individuals may experience multiple traumatic events without time to process and recover from one event before the next occurs, leading to what has been termed 'compound trauma' (Cockersell, 2018). This further exacerbates social exclusion through coping responses and the absence of appropriate service provision. This complex set of factors is known and understood to be important, yet approaching the issue is challenging.

To put this in context, a study reported on the work at a homelessness charity (St Mungo's) in the UK that provided counselling/psychotherapy to the customers (their preferred term) living in

the facilities. The data collected showed clearly that people who were homeless and with poor mental, did indeed have complex trauma histories and subsequently experienced further trauma whilst being homeless (Evolve, 2018). It has been known for some time that homeless people are often more likely to experience mental health difficulties, and that it is the complex of multiple traumas that underpins these difficulties (McGuire, Johnson, Vostanis, Keats, & Remington, 2009). This understanding is likely to be a helpful way for approaching people facing SMD rather than resorting to the use of specific diagnoses. Trauma has become understood to be an underlying phenomenon for a wide range of mental health difficulties and social problems (Joseph & Murphy, 2010), and the need for homelessness services to adopt trauma informed approaches is recognised (e.g. Homeless Link, 2017; Feantsa, 2017) although the mechanisms through which this is achieved are less well understood (Hopper et al., 2010). One obvious mechanism is the appropriate provision of psychological therapy. Talking therapy for people who are both homeless and mentally distressed is an area of growing interest in the field of SMD. However, access to talking therapy is often prevented due to a range of factors (We still need to talk coalition, 2013). In the sections below we consider some of the issues raised with regards to homelessness and mental health, substance misuse and access to the talking therapies.

> “homeless people are often more likely to experience mental health difficulties.”

Psychological therapy and SMD

The nature of homelessness and associated mental health and substance misuse issues, often coupled with offending, is a complex myriad of distress and disturbance. Whilst there are no doubts that structural and socio-economic factors play a significant role in constructing severe and multiple disadvantage, there is an argument that social solutions are not sufficiently equipped to bring about the necessary changes to people's lives. This is largely because it is believed that many of the issues that lead to the revolving cycle of distress and disturbance is attributable to psychological factors (Cockersell, 2011). In a study funded by the UK government, a psychotherapeutic programme was trialled through St Mungo's. In this project, Cockersell (2011) reported that homeless people were found to have high levels of psychological distress (demonstrated through meeting the criteria for personality disorder, anxiety and depression). Many were also dependent on drug or alcohol use. Each person in the study was able to access up to 25 sessions of psychodynamic psychotherapy. Therapy was shown to be helpful, with people attending the psychotherapy three times more likely to move from pre-contemplation to action on the Outcome Star, and twice as likely to have engaged in meaningful occupation by the end of their sessions, compared over the same time period with those who did not access psychotherapy.

In a related study, several of the therapists and a supervisor (Brown, Kainth, Matheson, Osborne, Trenkle & Adlam, 2011) who were all involved in the provision of therapy in the Cockersell (2011) study, reported on their experiences of offering therapy to a group of people typically excluded from psychotherapy services and considered it in the context of the notion of 'hospitality'. They described their work as engaging in the 'hubris of jettisoning a century of experience about who is within or beyond the reach of therapeutic help' (p. 311). What this refers to is the long-held belief in psychotherapy and counselling services that the homeless, addicts still using drugs, alcoholics still drinking and those that are experiencing psychosis are unable to engage in psychotherapy. This can commonly lead to exclusion from services at the point of referral, despite national clinical guidelines specifying that somebody should not be excluded from mental health services because of substance misuse (National Institute for Health and Care Excellence, 2016; Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Working Group, 2017) and the existence

of specific manualised treatments for individuals with coexisting trauma and substance misuse (e.g. Najavitas, 2002). These assumptions about an inability to engage in therapy were all challenged and confronted by the therapists in Brown et al.'s (2011) study. However, they also expressed a concern at the prospect of providing therapy to people who might not want to engage and told of instances of being met with hostility. In trying to understand the hostility that was sometimes present, they suggested that making psychotherapy available needs to be considered and the socio-political context must be understood; as psychotherapy is at its best, they suggest, when it is not covertly delivering an agenda on behalf of the State.

McGuire (2006) reported findings of a small-scale study of cognitive-behavioural therapy (CBT) with homeless men who had also been involved with the criminal justice system and were misusing alcohol and other substances. In this approach, staff were trained in CBT to formulate and address underlying problems of the target behaviours. All participants showed some improvements in self-efficacy and functioning whilst risk, rough sleeping, and violent behaviours also decreased. This pilot study offers promising findings for engaging and seeing change in psychotherapy for the homeless population that also are facing other difficulties. A key aspect of it is that psychotherapy was adapted and taken to the men within their setting, rather than them having to go to therapists.

> "Psychotherapy was adapted and taken to the men within their setting."

Similar positive outcomes have been found in the Psychology in Hostels project in Lambeth, where flexible provision of psychological therapy, provided directly in homelessness services, led to improvements in: mental health, interpersonal relating, meaningful occupation, and engagement in physical and mental health services and substance misuse services. Outcomes also included reductions in: self-harm, aggression and agitation, substance use, depression and anxiety and contact with the criminal justice service (Williamson, 2018), If psychotherapy is to be made available for people experiencing SMD, then there are some important issues to be examined. These refer largely to the history of scepticism within the psychotherapy profession of the usefulness of psychotherapy to this group (Brown et al., 2011) and also consider potential barriers for accessing psychotherapy if it is not provided flexibly.

Access to talking therapy and SMD

For many years a small number of researchers have recognised the potential contribution of counselling and psychotherapy for people experiencing homelessness. Koegal (1992) has suggested that counsellors need to be flexible, able to adapt in a culturally sensitive way to their clients and to have a flexible model of interpreting their professional role. Similarly, Bentley (1997) reported on a study on factors that can support the development of a positive therapeutic relationship between counselling and homeless people with mental health issues. Her findings, based in interviews with individuals who were homeless and mentally distressed who had accessed counselling support, stressed the importance of relationship-based approaches that provided opportunities for deep listening that felt like accepting experiences for clients. The study suggested that a person-centred approach, based on the counselling developed by Carl Rogers (1959), would be more effective for addressing the type of counselling that this client group might engage with.

The importance for psychotherapists and counsellors to be able to relate to homeless mentally distressed people should not be underestimated. Both Koegal (1991) and Bentley (1997) stressed the significance of being able to 'meet' the client in a way that was about making contact with the client as a person. The therapist's humility and respect for the client was essential, as was avoiding

> “The therapist’s humility and respect for the client was essential.”

any form of patronising or outsider stance. Both studies reported the importance of building a relationship from an insider perspective, and that this work can be started prior to the therapy commencing. The proposal was of a ‘pre-therapy’ alliance being formed offering the basic foundation upon which further work can develop. The development of a safe space for therapeutic work to take place was also featured and is described as creating a containing environment. This was reflected in the case study presented by O’Connor (2005), who advocates the need to establish clear and well-articulated expectations for the therapeutic work and process to take place.

A study by Campbell (2006) provides a good starting point for considering the issues of creating the therapeutic space for working with people who are homeless and mentally distressed. In her study, it was noted that the participants reported characteristically high levels of a range of psychological problems. One significant proposal from this study was for providers to recognise the meaning of space (a home), and how this can represent something inherently threatening to people where they might have been previously subjected to trauma or abusive experiences.

Past experiences of being helped, and stigma attached to needing help, might also prevent some individuals seeking help and being able to open up and talk about their experiences (Chaturvedi, 2016). The same study also recommended that therapists need to remove the potential threats by being patient, consistent in what they offer and making the counselling process clear, thus demystifying the idea of therapy. This seems particularly important when working with young adults who were homeless as Cormack (2009) reported that some clients did not trust their counsellors or counselling per se. Steps to ensure a sense of safety seem paramount.

The concept of a person-centred relationship also featured in a study by Archard and Murphy (2015) who researched people who were homeless and had alcohol problems to find out how they experienced a therapeutic social support intervention. The approach taken by the social support workers was grounded in Rogers' (1959) counselling approach and, therefore, held the concept of non-directivity as its central guiding principle. The clients using this service expressed how they appreciated both the relationships that workers built with them and how this became a conduit for important practical things to be done. The relational work meant that feelings of exclusion and alienation were mitigated but unfortunately the workers had to withdraw, and this left the clients experiencing loss and further isolation. The boundary associated with the length of therapeutic interventions is an important aspect in the development of any trusting environment in which therapy can take place. Where the client group are likely to have experienced many losses in their lives, knowing and feeling that there is enough time for them to build working relationships, at a pace and in the way that feels safe and appropriate to them, appears to be an essential requirement.

Summary

The need for talking therapy to address the psychological needs for people facing severe and multiple disadvantage is clear. However, less clear is a robust evidence base for how therapy can be and is helpful. In this review, we have identified only a small number of studies that have been conducted that considered the experiences of therapy by people facing SMD. From what little evidence is available, a number of factors appear to be consistently presented. These can perhaps be best stated as being the need for safety; trust; the importance of the therapeutic relationship; for therapists to be willing to come out of a professional role to meet clients as equals with respect. Psychodynamic and CBT have both been shown to have their merits in working with this group and person-centred counselling seems to have been particularly noticeable in its capacity for addressing and meeting the relational needs of individuals who are homeless and mentally distressed. The fact that these three approaches have been tried and all found to have their merits, concurs with much of the psychotherapy literature that what matters most is that the so called 'common factors', such as alliance, empathy, and cultural adaptation, which are associated with constructive changes and producing the benefits of psychotherapy (Wampold, 2015).

"The need for talking therapy to address the psychological needs for people facing severe and multiple disadvantage is clear."

As a result, this evaluation aims to address the following two questions.

1. Does accessing an embedded psychotherapeutic intervention for beneficiaries facing severe and multiple disadvantage lead to higher functioning, lower needs and improve level of demand on services compared to support as usual?

2. How do severely and multiply disadvantaged beneficiaries of services experience embedded psychotherapeutic interventions?

5. Methodology

In this evaluation a combination of quantitative and qualitative methods were used to analyse data provided by the sample of beneficiaries across two Fulfilling Lives Projects. The evaluators used quantitative data to investigate the first research question measuring the benefits of accessing embedded psychotherapeutic interventions that were available. Qualitative methods were used to investigate the experiences of beneficiaries who had received these psychotherapeutic interventions. This section of the report sets out in more detail the methods used to collect and analyse the data.

Design

A major benefit of an evaluation involving collaboration across two Fulfilling Lives projects is that a larger dataset can be collected for investigation. Embedded psychotherapeutic interventions were made available to beneficiaries in a non-randomised way meaning that this study used a quasi-experimental design with propensity score matching. Propensity score matching is a robust and strong design that enables the construction of a control group that is closely matched to the intervention group across important variables that are considered likely to affect the beneficiaries' prospects of entering into the additional intervention of accessing the embedded psychotherapeutic intervention. Using propensity score matching enables routine auditing of existing data to be used in robust evaluations of interventions where randomization is not possible or desirable.

Qualitative methods included the selection of beneficiaries who were willing to be interviewed as part of the usual business of auditing and evaluating the services provided at both of the Fulfilling Lives projects. Beneficiaries took part in a single semi-structured interview. These approaches combined to create a mixed methods analysis of embedded psychological interventions for multiply disadvantaged beneficiaries.

Participants

The participants in the current evaluation were 289 beneficiaries of two Fulfilling Lives Project across Nottingham (N=211) and, the South East (N=78). The beneficiaries were all identified as experiencing severe and multiple disadvantage, and had accessed the support available through their local Fulfilling Lives project. Beneficiaries who had provided at least two data entries were included in the evaluation. Of these, 26 participants (n=14 from Nottingham and n=12 from South East) engaged with the embedded psychotherapeutic intervention that was available. Access to the psychological therapist was generally managed through project coordinators. Beneficiaries were to some extent self-selecting, although it is recognised that some project coordinators might be more or less inclined to encourage their beneficiaries to access psychotherapy and might gate keep referrals to therapists, based on their own views of an individual's ability to make use of therapy. The Table 1 provides a breakdown of the total sample and the sample that elected to engage with the psychotherapeutic intervention by gender, ethnicity and age.

Table 1: Demographic data for ethnicity and gender by total sample and intervention group

	NOTTINGHAM (INTERVENTION)	SOUTH EAST (INTERVENTION)	TOTAL (INTERVENTION)
Gender			
Male	152(10)	33(5)	185(15)
Female	59(4)	38(7)	104(11)
Total	211(14)	78(12)	
Ethnicity			
White	174(14)	72(11)	246(25)
Asian	8(1)	1(0)	9(1)
Black	14(0)	1(0)	15(0)
Mixed race	13(0)	3(0)	16(0)
Total	209(15)	77(11)	286*(26)

*missing data for 3 cases

Data collection

Data were collected from all participants when they accessed the Fulfilling Lives project and was subsequently collected at three-month quarterly intervals for the duration of their involvement in the project. Data was collected through the use of self-report questionnaires that focused on their wellbeing/functioning, behaviour and use of other services. The data were collected in scheduled review meetings with beneficiaries.

Intervention

The intervention was access to an embedded psychotherapy service based within the broader Fulfilling Lives project. The therapeutic workers who provided the counselling sessions were both trained in counselling and cognitive behavioural therapy and their work with beneficiaries drew on each approach depending on the therapist's perception of the client's needs. Beneficiaries were able to access therapy for as many sessions as required, and for as long as they remained within the project. There was one therapist working at each Fulfilling Lives project, both were female and White.

Measures

There were two primary outcome measures used in the services. These were the Homelessness Outcome Star and the New Directions Team (NDT). The Homelessness Outcome Star was developed by Triangle Consultancy together with St Mungo's Charity and has been widely used in the field of homelessness. The measure assesses ten areas of functioning (see appendix for a version of the scale). The scale has good internal reliability with a Cronbach's alpha .91 (Good, 2018). High scores on the Homelessness Outcome Star indicate better overall functioning. The Homelessness Star is scored using a 10-point Likert type scale with the range of scores between ten and one hundred.

The second outcome measure is the NDT is a measure that aims to assess beneficiary needs across a range of areas of functioning. There are ten areas of needs (see appendix for a version of the NDT) that are rated using a 5-point scale with scores ranging on each item between zero and four. There is no psychometric data available for the NDT although it is used nationally across the entire range of Fulfilling Lives projects.

As a secondary outcome of the project, service use data was collected. This involved simply counting the level of use of other services. There were services that were consider as indicating negative outcomes such as 'days in prison' and others that indicated positive outcome such as 'days in rehab'. This measure can also be used to assess the cost effectiveness of an intervention.

The measures were collected from the intervention group at the start and end of their therapeutic intervention which was also typically the point they ended their involvement with the project. The measures used for analysis for the control group were collected at their first and last point of contact with the project.

Results

In this section, the results from the quantitative analysis are presented. The primary question the evaluation aimed to answer was whether accessing an embedded psychotherapeutic intervention was helpful for beneficiaries and whether this was more helpful than not accessing the intervention and continuing with the support being provided as usual. In order to do this, we first created a control group that was matched to the group that accessed the intervention. To do this, SPSS propensity score matching was used. The twenty-six beneficiaries who accessed the intervention were matched with a group of twenty-six beneficiaries that we from the entire sample of 289 beneficiaries. This provided a sample of fifty-two beneficiaries for the data analysis. The control group was constructed based on the following criteria: 1) age, 2) Fulfilling Lives area, and 3) pre-intervention score on the outcome star. Propensity score matching is considered to be a very robust approach to creating a control group and is typically used when it is not possible to use a randomised control trial design to test the effects of an intervention.

The descriptive data for the two groups are shown below.

Table 2: Descriptive data for intervention and control groups

	N	**AGE (YRS)**	**MONTHS IN PROJECT**	**GENDER**
Intervention Group	26	44.2	38.1	Male $n=15$ Female $n=11$
Control Group	26	38.2	29.7	Male $n=18$ Female $n=8$

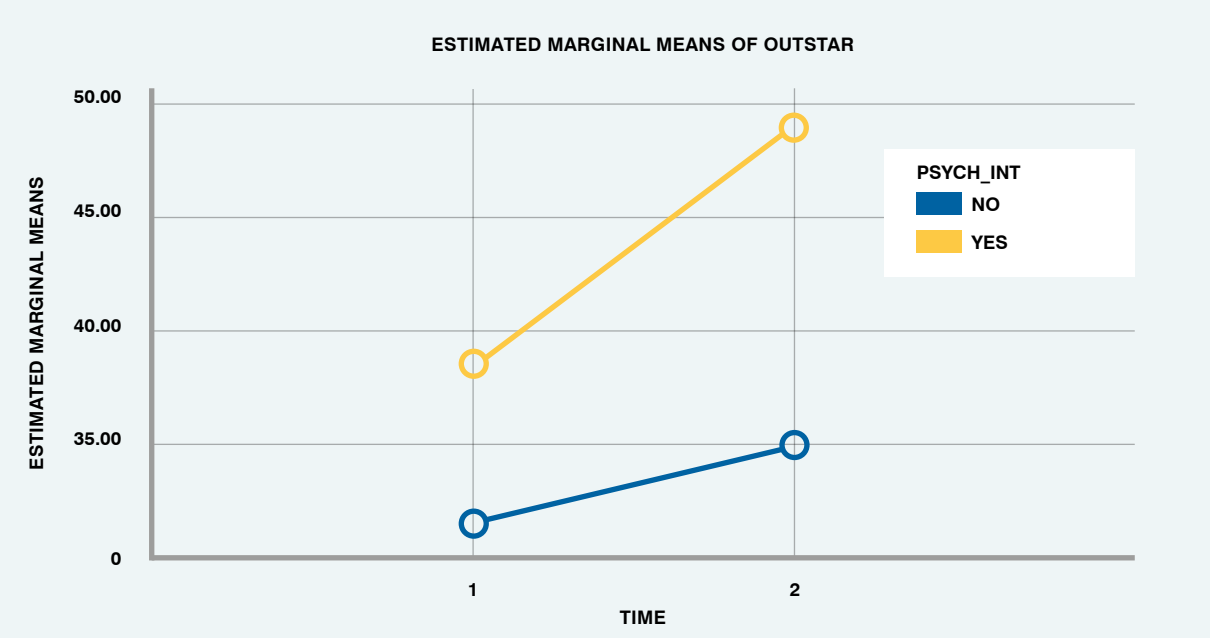
Having constructed the control group, a two-way mixed ANOVA with repeated measures was used to investigate the differences between the intervention group and the control group for the main measure of improvement which was the Homelessness Outcome Star. The analysis was repeated for the second measure of improvement, the NDT. The table below shows the mean scores for the two outcome measures at each time point for both the intervention and the control group.

Table 3: Mean scores and standard deviations for outcome start and NDT pre and post for intervention and control groups

	N	MEAN OUTCOME STAR		MEAN NDT	
		Pre(S.D.)	Post(S.D.)	Pre(S.D.)	Post(S.D.)
Intervention	26	39.1(16.1)	49.5(20.4)	24.3(8.9)	22.3(9.9)
Control G	26	31.4(15.5)	34.8(13.0)	30.4(4.4)	25.6(7.8)

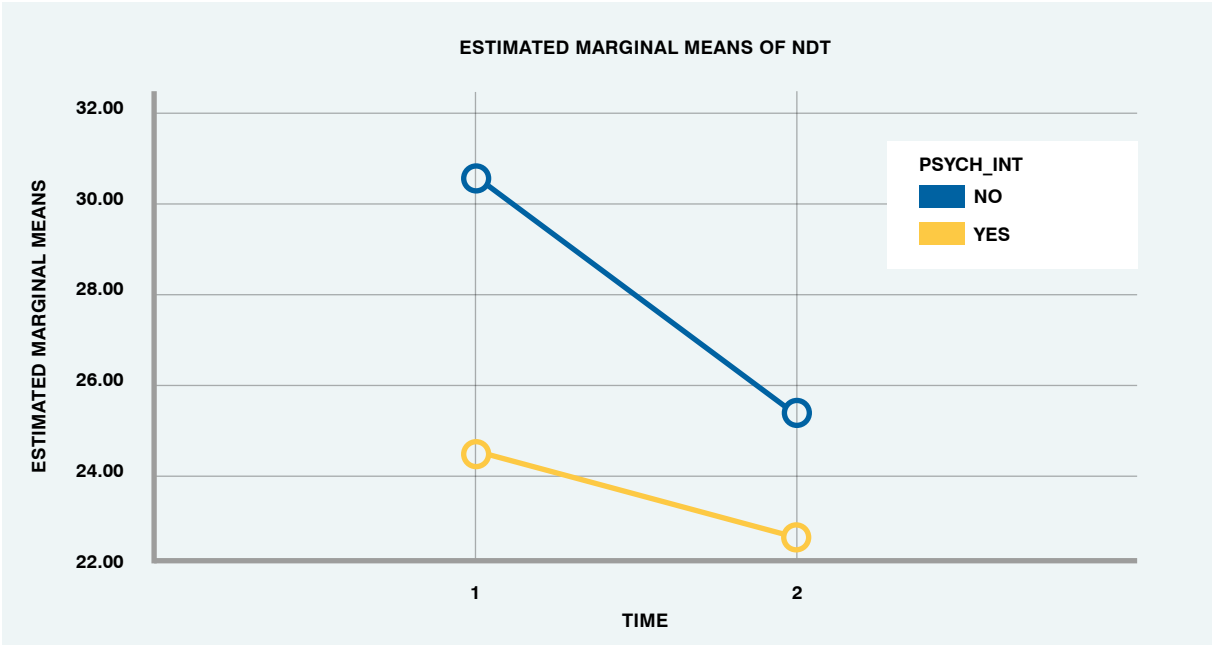
The analysis showed that there was no statistically significant interaction between the pre-post Outcome Star across the two groups ($F=.012$; $p>.05$) as measured using the difference between the amount of improvement shown by the intervention group compared with improvement in the control group. However, both groups showed statistically significant improvement on the Outcome Star over time ($F=7.96$: $p<.01$). The chart below shows the two groups compared to each other.

Figure 1: Mean scores for Outcome Star at Time 1 and 2 by Intervention and Control



The analysis also showed that there was no statistically significant interaction between the pre-post NDT scores across the two groups ($F=1.56$; $p>.05$) as measured using the difference between the amount of improvement shown by the intervention group compared with improvement in the control group. However, both groups showed statistically significant improvement in scores on the NDT over time ($F=8.96$: $p<.01$). The chart below shows the two groups compared to each other.

Figure 2. Mean scores for NDT at Time 1 and 2 by Intervention and Control



Analysis of service use

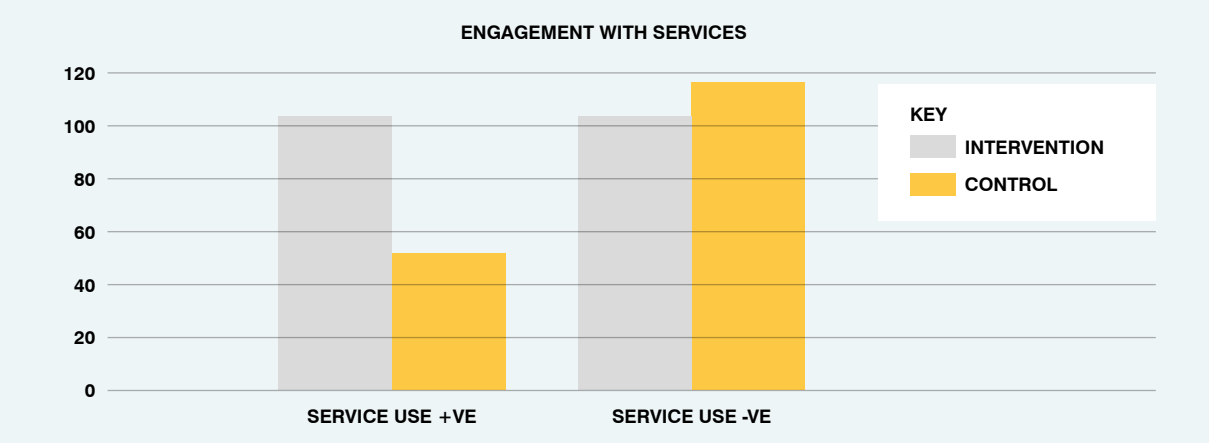
The data were analysed to consider the effects of the psychotherapeutic intervention on service use. Service use data was collected by counting instances of contacts with services. The service use data referred to either positive contacts or negative contacts. Positive and negative contacts variables were created from the sum total of contacts of either category.

A Poisson regression was conducted to predict the number of contacts with services over the period that a beneficiary was registered on the programme based on whether the beneficiary engaged in the psychotherapeutic intervention or not, their post intervention Outcome Star and NDT scores and the number of months they were registered in the Fulfilling Lives programme. With regards to the negative contacts, not engaging with the intervention meant there was 1.442 (95% CI, 1.357 to 1.534) more contacts in the control group which is the same as saying a 4.2% increase in contacts which is statistically significantly greater than compared to the intervention group ($p<.005$).

To test for positive engagements a further Poisson regression was conducted with the same variables in the model. With regards to positive contacts, the model suggested there was .762 (95% CI, .706 to .822) more contacts for the intervention group which is the same as saying there were 6.2% more contacts with services for the intervention compared to the control group.

This finding is important as it suggests that those beneficiaries accessing the psychotherapeutic intervention were less likely to use services for what might be considered negative consequences than those in the control group but were more likely to use services for positive consequences.

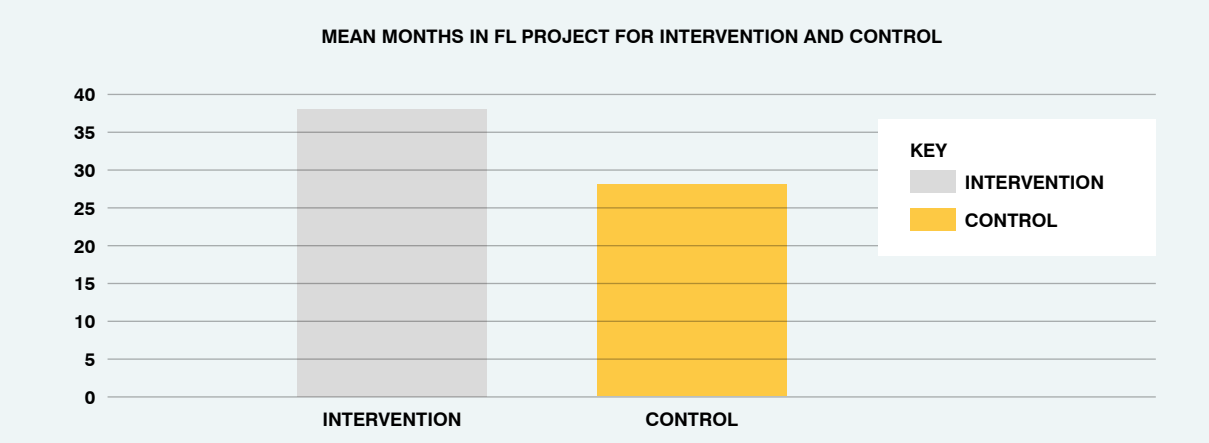
Figure 3: Engagement with services by intervention and control



Engagement with Fulfilling Lives

A final analysis was conducted to test the effect of the intervention on the number of months engaged in the Fulfilling Lives project. A one-way ANOVA was conducted and showed that there was a statistically significant effect ($F=5.124$, $p<.05$) with those accessing the psychotherapeutic intervention staying engaged with the Fulfilling Lives programme for longer. The Figure below shows the difference between the intervention (Mean months = 38.1) and control (Mean months = 28.7) by the number of months engaged in Fulfilling Lives.

Figure 4: Mean months in FL project for intervention and control



Qualitative analysis

The second question that this evaluation aims to address is an investigation of the experiences of beneficiaries that have used and engaged with the embedded psychotherapeutic intervention. In order to do this, the evaluators conducted interviews with four beneficiaries. The aim of this part of the evaluation was to get behind the numbers associated with the use of the service and understand the how and why the findings outlined above can be explained.

The qualitative analysis was conducted after each interview had been transcribed verbatim. Each interview lasted for approximately 30 minutes. After the interviews were transcribed, two evaluators conducted thematic analysis. Thematic analysis is an approach to qualitative research that involves the generation of themes from the interviews conducted with beneficiaries. Each interview was individually analysed and then all of these analyses were combined to identify the major themes. Each major theme was created out of a number of subthemes. The table below shows the major and component sub themes.

Table 4: Themes representing beneficiaries' experiences of intervention

THEMES				
1 Previous experience of support	**2 Motivation for seeking support**	**3 Positive engagement**	**4 Barriers and hindering aspects**	**5 Impact of intervention**
Past use	Hopes	Valued aspects of approach	Difficulties encountered	Impact and effects
Barriers to access	Fears	Valued aspects of sessions		
Feelings about past experience		Attributes of workers		
Impact of past experience				

In the section below the main themes and each subtheme are presented with an exemplar of the interview transcript that represents the theme. The themes have been organised to try present the journey for beneficiaries starting with *previous experiences of support.* These are then followed by *motivation* for seeking support and aspects that were considered *positive engagement.* The final two themes represent experiences of *barriers and hindering aspect and the impact of intervention.*

1. Previous experience of support

People who are severely and multiply disadvantaged will have come into contact with services before and over many years. These contacts will have been experienced in a variety of ways. In order to understand how beneficiaries experienced the embedded psychotherapeutic intervention it was important to understand something about their previous experiences of accessing or engaging with support. Beneficiaries reported a variety of experiences of accessing support prior to the intervention. For example, one beneficiary said that tried a talking therapy before saying, *'I was, I just got clean off drugs and alcohol and I was diagnosed with post-traumatic stress disorder and when I had my psychologist/psychiatrist do a report they suggested that I needed CBT'' (Nottingham – Jenny).* Sometimes, beneficiaries found the support they received quite overwhelming and perhaps found it difficult to distinguish between professionals fulfilling different roles such as key workers or therapist, *''I've got so many key workers. But they're all key workers for different issues''. (Brighton – Ben).* There were also instances where beneficiaries reported having to engage with a therapist against their will, *''Hmm, it was some counselling I had in jail. I can't even remember it, it was so long ago. I think it was through victim support, not victim support, erm rape counselling or*

something'' (Nottingham – Jenny). In contrast, sometimes beneficiaries commented on the barriers to accessing support such as needing to develop trust in their worker, *''Oh gosh, it was so long ago now. I think… no… I'm a very, very private person. I need to get to know somebody to trust them.'' (Brighton – Lee).* Where trust was an issue it is difficult to access support and there is a chance the offer of support will be rejected *''I think a lot of it would be my fault because if somebody had offered me I'd have said, get lost, go away''. (Brighton – Lee).*

Attending and remaining in contact with support services is challenging. Beneficiaries said that they might often not attend sessions even when support was available. This history of having been in contact with many services is one that travels with beneficiaries into all new opportunities. Some have been in and out of services many times *''…because if you don't get to meetings and stuff, then they think you really can't be arsed. That you've disengaged, yeah, yeah''. (Brighton – Ben).* The transient nature of both beneficiaries and the workforce was also an important feature of the history that beneficiaries might bring to the intervention, one said, *''No because, when you're in these sort of situations you get workers that sort of move on from one job to another or get relocated or whatever, so it's kind of like, sort of distrusting, and I was like I don't really want to open up. And you have to keep saying the same thing over, and over, and over… It was, but it was like, oh my gosh, every day I've got three different key workers and they're all different every day, and I was like going to the point where I was just like… I just want to go to sleep! (laughs) I'm really tired, from talking''. (Brighton – Ben).*

The result of this unsatisfactory engagement can be significant because it means that beneficiaries can become hopeless about the chances of getting any support that might help them. As one beneficiary poignantly said, *''Yeah. You just give up the will in the end, it's just like you know what? I can't be bothered, you know what I mean?'' (Brighton – Ben).*

2. Motivation for seeking support

Of course, it is understandable that with long histories of unsatisfactory support, or support that just doesn't seem to be able to help a beneficiary in the long term, it would be understandable if they were to give up trying to get help. However, something drives them on and even in the most challenging circumstances there seems to be a striving for improvement in ones circumstances. Beneficiaries pointed to this in their motivations for seeking help with the psychotherapeutic intervention. There was hope. A hope to *''erm… to get me head, to get me head sorted out… cus God knows what I've had… it's like I don't want to be down here anymore… I want to be up there'' (Nottingham – W). There was hope for ''Life''. Life in general? ''Yeah''. (Brighton – Ben)* or hope for getting back *''Where I used to be, full of fun and laughing, you know, just enjoying life''. (Brighton – Lee).* More specifically, beneficiaries reported a desire to improve themselves such as this, *''I don't like being all the way down here… I want to get my confidence back up and everything.'' (Nottingham – W).*

Despite all of the hopes for how the psychotherapeutic intervention might help them, beneficiaries reported they were apprehensive and had some fears. One beneficiary said, *''I just felt like, oh god what's it gonna… what's it gonna be like. Am I going to cope with it and everything.'' (Nottingham – W).* Another said about meeting their therapist, *'I was scared to meet her…to tell you the truth. It's been, it's been, it took me ages to meet her because I was, I was, I didn't want to go on me own (Nottingham – T).*

3. Positive engagement

Valued aspects of the approach - Overcoming previous support experiences and being motivated to engage with the psychotherapeutic intervention provided the foundation for their work in therapy. Once beneficiaries were in contact with their therapist they talked about the process of being engaged. A sense of the worker being committed was really important to beneficiaries and one

said, *''Obviously because she was a CBT worker. I think if Rowan had not been so perseverant. Right I'm coming back, I'm coming back. She kept coming, she kept knocking the door'' (Nottingham – Jenny).*

Having a therapist that was engaged and committed was important but so was their capacity for understanding and empathising deeply with the beneficiary, *''More or less after I got attacked. I didn't tell anyone but Rowan knew something was wrong''. (Nottingham – Jenny).* Similarly to feeling understood, being accepted by the therapist was crucial and was shown through their non-judgmental attitude to whatever the beneficiary wanted to discuss, *''Well like I just said y'know, if somebody was gay or like she knew that Bill had died and that he was a lot older than me, she knew we'd had some problems whatever, but she didn't criticise me and she never criticised him''. (Brighton – Lee).* Feeling safe and secure in the relationship with the therapist was very helpful for exploring personal material, *''Before (FL Psychological intervention) I used to be so scared in saying what I was thinking or feeling, what my personal issues were with my husband and what was going on and I would hold a lot back because of my fear of everything getting reported to social services'' (Nottingham – Jenny).* The trust that was fostered through the relationship did not appear spontaneously and it was the consistency in therapists attitudes that enabled trust to develop over time, *''But it only took me about a month to trust her, and she was like, I'm not going anywhere '' (Brighton – Ben).*

One of the most obvious ways that beneficiaries felt and experienced their therapist's acceptance of them was through the flexible approach the therapist adopted. These two beneficiaries both experienced and benefited from the flexible accepting approach, one said *''We used to meet at Asda and then I was having and then when we were having my sessions, I was having a lot of issues and a lot of resentment around my husband before I relapsed and Rowan (Psychological worker) was like. Well because my husband, with him being Muslim does not like outside help and it is a really difficult thing to let all these people in''. (Nottingham – Jenny).* The other said *''Yeah, yeah, but it was such a sterile situation, that I didn't feel capable of talking about stuff, so, my support worker*

(FL) used to come to me and I felt more comfortable to talk about stuff, in my own flat. Umm, it didn't work in that environment [acute mental health hospital] at all. Seriously it just didn't, and umm, that support worker said that other people have said that as well '' (Brighton – Ben).

Another way that beneficiaries felt accepted was through the therapists' tolerance and accommodation of beneficiaries' lives which often meant they couldn't always keep to scheduled appointments. For example, one beneficiary said, *'If for some reason I wasn't really feeling up to it, she was really casual about it and go okay that's not problem, I'll meet up with you next week. And, so, I didn't feel pressured'' (Brighton – Ben).* Sometimes this also meant stopping and restarting therapy when the beneficiary felt it most suited them and the therapist remained open to this by following the beneficiaries' needs, *''I'm quite eager to start it back up actually because I was crap at doing my homework last time. Whereas this time, from my relapse I've learnt so much about myself that I'm quite eager to start back on it. Yeah'' (Nottingham – Jenny).* And there were times when the length of the session was able to be altered to suit the beneficiary, *''About an hour or 2. Sometimes longer, we'd often go over and if Rowan didn't have another appointment, she wasn't bothered about that you know.'' (Nottingham – Jenny)* and this was extended to in between sessions also, *''Yeah, but if I've got any problems I can just ring her up and everything so that's good. So like if I'm at home and I'm upset I can just ring her up and if I feel like… like I'm feeling like I'm going to do something stupid I can just ring her up and [coughs] just speak to Rowan'' (Nottingham – W).*

Valued aspects of sessions – In addition to the valued aspects of the approach to therapeutic work being undertaken there was a number of features that specifically related to the therapist and their personal attributes and attitudes. These were linked to valued aspects of the sessions themselves. In reporting what was valued the beneficiaries said, *''I'm not sure, to be honest, because I was, I'd been going through a really tough time, and she was just a kind listening ear''(Brighton – Ben).* The same person went on, *''I think I just needed support. By somebody that actually understood what I was going through and had an understanding, and empathy'' (Brighton – Ben).* Understanding, for the beneficiary, was considered very important and the therapist could show this by adapting their style to meet the client and make them feel safe and address the power difference in their roles, *''So I think Rowan does what suits my personality and suits my needs and my mental health. I'm sure if someone was a bit more quiet and within themselves she will suit them'' (Nottingham – Jenny).* Other personal attributes included kindness, openness, accepting, and a sense of humour. A quote from one beneficiary captures it well, *'I think Natasha and me we've got the same sense of humour…I took to her… her warm friendliness straight away…She's just… she's done everything y'know, she's done absolutely, I couldn't have asked for a nicer person…I'd rather shut people away. Whereas like with Natasha I can really get on with her'' (Brighton – Lee).*

The opportunity to work specifically on issues that were felt important was also something that beneficiaries valued about the intervention. Of these, focusing on traumas that had occurred was consider very important in helping to gain more awareness of triggers and risks associated with past event and how these affect current behaviour and emotional states. These two beneficiaries both commented, *''Now because I've had that intensive support from Rowan, especially since I was sexually attacked you know. My trust with Rowan is so high that I wont have those issues now''. (Nottingham – Jenny).*

''Because I… had problems with my ex-partner and everything and that lot… and she has been really helpful since, like he passed away and everything'' (Nottingham – W).

The approach that the therapist took to supporting the exploration of traumatic events was also important and the therapist's creativity really helped, *''And also she thought out of the box as well, so she actually took notice of needs that I might need, like, and really tried to help me in a different way''. (Brighton – Ben).* At times, a more focused approach was also valued such as when the therapist draws on CBT skills and techniques, *"…I know Rowan (FL Psychological Worker) kinda throws questions out there. That are CBT questions, without me even realise, so I know that when we sit down to do a CBT session, we will be a lot further along than probably we would have been*

because of that intensive support, and the CBT without me realising'' (Nottingham – Jenny).

4. Barriers and hindering aspect

Difficulties encountered – Whilst there were many positive experiences and aspects to the intervention there were of course some challenges and difficulties also experienced. These often had the effect of limiting capacity for accessing the sessions and risked leading to termination or disengaging. Other factors included beneficiaries that were impacted by drug or alcohol misuse, *'I was just going through a really, really, bad two and a half year relationship and it was on and off and up and down and everything, and decided that it would be probably better that I went to rehab and then started that up again afterwards.'' (Brighton – Ben).* Sometimes it was the case that the therapist was unavailable and this caused some frustration for beneficiaries, *''Yeah, exactly, too busy. So I can't get in touch with her when I want to and I'm having to get in touch with PDC to get in touch with her and I think if I didn't have to do that…'' (Nottingham – T).* Similarly, beneficiaries also noted that their own limits to being available presented a challenge at times, *'Not, not recently. There's a period where, not until I went to hospital you was lucky if people could get a hold of me let alone, let alone engage with me. (Nottingham – Jenny).*

5. Impact of intervention

Impact and effects – There were a number of impacts of engaging with the intervention that were reported by beneficiaries. For example, learning how to cope with and gaining insights into problems, *''No, no it's all good. She's told me to write things down. She's like answering questions that have puzzled me. So no it's all good'' (Nottingham – T).* Beneficiaries reported having better wellbeing and feeling calmer or of regaining a sense of belief in oneself, *''My sanity back I think. No probably that's… because I've still got my sanity. Yeah just myself back again I suppose…She just gave me, uhm, I mean I was ne- I've never been suicidal in my life, put it that way. But she gave me – so when I say this, don't take it the wrong way – she just gave me a reason to think, to believe more in myself.'' (Brighton – Lee).* The intervention proved to be a real stepping stone for many people as they were able to access other help and support and gain access to important services that could lead to further improvements. Of course, the intervention was not a panacea but as one beneficiary said, *''I am getting there… so… with Rowan's help.'' (Nottingham – W).*

Discussion

In this evaluation we have investigated whether an embedded psychotherapeutic intervention was successful in improving scores on the Homelessness Outcome Star, lowering scores on the NDT as compared to a control group who accessed the support as usual. We additionally considered whether there were any differences between the intervention and control groups on service use. Finally, we considered the experiences of accessing the psychotherapeutic intervention to understand more about beneficiaries' experiences and inform future provision.

The beneficiaries that accessed the psychotherapeutic intervention showed statistically significant improvement on the Homelessness Outcome Star and the NDT but this was not statistically significantly greater than the improvement that the control group also made where beneficiaries accessed support as usual. So how can we understand this finding? It is clear that the robust analysis we conducted here shows that the work of the fulfilling lives project is having real and meaningful impact on beneficiaries' lives.

> "...the fulfilling lives project is having real and meaningful impact on beneficiaries' lives."

The control of support of usual is of course not a neutral control. The work that skilled and professional support workers carry out is meaningful to beneficiaries and can lead to significant improvements. Therefore, for the psychotherapeutic intervention to have shown even greater improvement this would have been difficult to achieve. Similarly, the control of support as usual also means that beneficiaries in that group were engaged and motivated for change, at least to the extent they were part of the project. It might be that they simply did not need further psychotherapeutic input at that time whereas those that opted for the intervention might have required the additional support in order to maintain their trajectory towards improvement. From this, it could be argued that having the embedded psychotherapeutic intervention available is important as it enables beneficiaries to access a wider array of support that can suit their needs. It is not possible to know whether these beneficiaries would have remained within the FL project had they not been able to access a psychotherapeutic intervention although that is of course possible. One important 'myth' to dispel from this finding is that people who are very distressed as a result of severe and multiple disadvantage are unable to benefit from talking therapy. This study provides evidence for the fact that where this is available it can be useful for beneficiaries.

The analysis also showed that beneficiaries who engaged in the psychotherapeutic intervention were more likely to engage with services that were considered positive engagements. This is a very interesting finding and has a great deal of potential for considering cost effectiveness of a psychotherapeutic intervention. Similarly, beneficiaries in the support as usual group used more services that are considered negative engagements and once again this could have significant cost effectiveness implications. Further research into this area is recommended. Of course, all of these findings need to be interpreted cautiously as the only true test of the hypothesis is through a true experiment with randomization into the different groups.

The qualitative analysis provided insightful evidence and support for the beneficial experiences that beneficiaries have when accessing the psychotherapeutic intervention.

6. Recommendations

Psychotherapeutic interventions should be commissioned as a key part of local areas' responses to people experiencing severe and multiple disadvantage. Such provision can support the development of individuals' insight into problems and ability to cope with them and be a stepping stone towards other support and improvements. This is likely to lead to benefits not only to mental health but also in other aspects of SMD.

To be successful for people facing SMD, psychotherapeutic interventions need to be provided with an alternative and more flexible approach than is commonly the case, particularly in NHS funded services such as IAPT.

This alternative approach has two main elements which need to be incorporated into service delivery:

- First, although building trusting relationships between therapist and client is always important, additional emphasis should be placed on this and time provided to achieve it. This needs to be especially the case in the early stages of engagement bearing in mind people experiencing SMD will have often had negative past experiences of services, (including mental health services). Sometimes contact with services can compound past trauma and create a strong reluctance and even fear of engagement.

- Second, consideration needs to be given to flexibility in how, when and where therapy is delivered. Fixed times and locations may not always be the best approach, and missing appointments should not be seen as an indicator the beneficiary is not seeking the intervention. Using locations where a beneficiary feels more comfortable and not pressured to be at an appointment at a particular time will be more likely to help to establish successful engagement in the longer term. Caseload size and work arrangements need to reflect this, as there will be some weeks where a beneficiary may not be seen and others where several meetings are needed.

Whilst the above approach would benefit all psychotherapeutic services seeking to work with people experiencing SMD, the specific model evaluated in this report; where a therapist is included as part of a multi-disciplinary team working in a person-centred and strengths-based way, will likely have particular benefits. These benefits can include developing specific knowledge of SMD, better liaison with other workers and reducing referral and assessment processes, which can be especially stressful for people experiencing SMD.

Whilst the study found Homelessness Outcome Star gains amongst beneficiaries engaging with psychotherapeutic interventions, it was not possible to assert fully that these gains were due to the intervention. So, further evaluation would be useful, particularly the interaction of psychotherapeutic interventions with other types of intervention, such as support from Navigators/Coordinators and specific housing interventions such as Housing First.

All but one of the Beneficiaries receiving the psychotherapeutic intervention in the study were White British, and further work is needed to understand how psychotherapeutic interventions for people from BAME communities experiencing SMD might best be delivered.

7. References

Archard, P. & Murphy, D. (2015). A practice research study concerning homeless service user involvement with a programme of social support work delivered in a specialized psychological trauma service. *Journal of Psychiatric and Mental Health Nursing, 22*, 360-370. https://doi.org/10.1111/jpm.12229

Banfield, M. & Forbes, O. (2018). Health and social care coordination for severe and persistent mental illness in Australia: a mixed methods evaluation of experiences with partners in recovery program. *International Journal of Mental Health Systems, 12*:13. https://doi.org/10.1186/s13033-018-0194-2

Baxter, E., & Hopper, K. (1982). The new mendicancy: homeless in New York City. *The American journal of orthopsychiatry, 52*(3), 393–408. https://doi.org/10.1111/j.1939-0025.1982.tb01426.x

Bentley, A. (1997). The psychological effects of homelessness and their impact on the development of a counselling relationship. *Counselling Psychology Quarterly, 10*(2), 195-210. https://doi.org/10.1080/09515079708254172

Bramley, G., Fitzpatrick, S., with Edwards, J., Ford, D., Johnsen, S., Sosenko, F., & Watkins, D. (2015). Hard Edges: *Mapping severe and multiple disadvantage.* https://lankellychase.org.uk/resources/publications/hard-edges/ accessed on 31st January 2020.

Brown, G., Kainth, K., Matheson, C., Osborne, J., Trenkle, A., & Adlam, J. (2011). An hospitable engagement? Open-door psychotherapy with the socially excluded, *Psychodynamic Practice, 17*(3), 307-324, https://doi.org/10.1080/14753634.2011.587605

Campbell, J. (2006). Homelessness and containment–a psychotherapy project with homeless people and workers in the homeless field. *Psychoanalytic psychotherapy, 20*(3), 157-174. https://doi.org/10.1080/02668730600868922

Chaturvedi, S. (2016). Accessing psychological therapies: Homeless young people's views on barriers and facilitators. *Counselling and Psychotherapy Research, 16*(1), 54-63. https://doi.org/10.1002/capr.12058

Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017). *Drug misuse and dependence: UK guidelines on clinical management.* London: Department of Health.

Cockersell, P. (2011). Homelessness and mental health: adding mental health interventions to existing social ones can greatly enhance positive outcomes. *Journal of Public Mental Health, 10*(2), 88-98. https://doi.org/10.1108/17465721111154284

Cockersell, P. (2018). Compound trauma and complex needs. In: P. Cockersell (Ed.) *Social exclusion, compound trauma and recovery.* London: Jessica Kingsley Publishers, pp.26 - 36.

Cormack, J. (2009). Counselling marginalised young people: A qualitative analysis of young homeless people's views of counselling. *Counselling and Psychotherapy Research, 9*(2), 71-77. https://doi.org/10.1080/14733140902823755

Dennis, D. L., Buckner, J. C., Lipton, F. R., Frank, R., & Levine, I. S. (1991). A decade of research and services for homeless mentally ill persons: Where do we stand? *American Psychologist, 46*(11), 1129-1138. https://doi.org/10.1037//0003-066x.46.11.1129

Eaton, J., Des Roches, B., Nwaubani, K., & Winters, L. (2015). Mental health care for vulnerable people with complex needs in low-income countries: Two services in West Africa. *Psychiatric Services, 66,* 1015-1017.
https://doi.org/10.1176/appi.ps.201500066

FEANTSA (2017). *Recognising the links between trauma and homelessness.* Available at:
https://www.feantsa.org/download/feantsa_traumaandhomelessness030734712190529468107 38.pdf

Fischer, P. J. & Breakey, W. R. (1991). The epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist, 46*(11), 1115-1128.
https://doi.org/10.1037//0003-066x.46.11.1115

Fulfilling Lives Project.
https://www.fulfillinglivesevaluation.org/ Accessed on 31st January 2020.

Good, A. (2018). Outcome Star Psychometric Factsheet: Homelessness Star. Available
https://www.outcomesstar.org.uk/wp-content/uploads/OS-Psychometric-Factsheet_Homelessness-Star.pdf accessed on 02/07/20.

Harvey, C., Brophy, L., Parsons, S., Moeller-Saxone, K., Grigg, M., & Siskind, D. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian and New Zealand Journal of Psychiatry, 50*, 534-547.
https://doi.org/10.1177/0004867415610437

Hopper, E.K., Bassuk, E.L., & Oliver, J. (2010). Shelter from the Storm: Trauma-Informed Care in homelessness service settings. *The Open Health Services and Policy Journal, 3*, 80 – 100.

Homeless Link (2017). *An introduction to Psychologically Informed Environments and Trauma Informed Care. Briefing for homelessness services.* Available at;
https://www.homeless.org.uk/sites/default/files/site-attachments/TIC%20PIE%20briefing%20March%202017_0.pdf.

Joseph, S. & Murphy, D. (2014). Trauma as a unifying concept for social work. *The British Journal of Social Work, 44*(5), 1094-1109.
https://doi.org/10.1093/bjsw/bcs207

Koegal, P. (1992). Through a different lens: An anthropological perspective on the homeless mentally ill. *Culture, Medicine and Psychiatry, 16,* 1-22.
https://psycnet.apa.org/doi/10.1007/BF00054437

Lee, K. S., Harrison, K, Mills, K. & Conigrave, K. M. (2014). Needs of Aboriginal Australian women with comorbid mental and alcohol and other drug use disorders. *Drug and Alcohol Review, 33,* 473-481.
https://doi.org/10.1111/dar.12127

Levine, I. S. & Huebner, R. B. (1991). Homeless persons with alcohol, drug, and mental disorders: Introduction to section one. *American Psychologist, 46*(11), 1113-1114.
https://psycnet.apa.org/doi/10.1037/0003-066X.46.11.1113

McGuire, N. (2006). Cognitive Behavioural Therapy and homelessness: A case series pilot study. *Behavioural and Cognitive Psychotherapy, 3*(1), 107-111. https://doi.org/10.1017/S1352465805002493

McGuire, N., Johnson, R., Vostanis, P., Keats, H. & Remington, R. E. (2009). Homelessness and complex trauma: A review of the literature.
http://eprints.soton.ac.uk/id/eprint/69749

Mulder, C. L., Ruud, T., Bahler, M., Kroon, H., & Priebe, S. (2014). The availability and quality across

europe of outpatient care for difficult-to-engage patients with severe mental illness: A survey among experts. *International Journal of Social Psychiatry, 60,* 304-310. https://doi.org/10.1177%2F0020764013485941

Najavitas, L. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse.* New York: The Guildford Press.

National Institute for Health and Care Excellence (2016). *Co-existing severe mental illness and substance misuse: community health and social care services.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

O'Connor, J. (2005). Between the street and the consulting room: The role of therapeutic frame in working with homeless clients. European Journal of Psychotherapy, Counselling and Health, 7(4), 217-233. https://doi.org/10.1080/13642530500367597

Sosenko, F., Bramley, G., Johnsen, S. (2020). *Gender Matters: Gendered patterns of severe and multiple disadvantage in England.* Available at https://lankellychase.org.uk/wp-content/uploads/2020/02/Gender-Matters-full-report-Feb-2020.pdf accessed on 20/05/20.

Sandu, R. D. (2019). What is the profile of workers who build effective relationships with young people facing severe and multiple disadvantages? *Journal of Community Psychology,* 1-18. https://doi.org/10.1002/jcop.22256

Wampold, B.E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270 – 277. https://doi.org/10.1002/wps.20238

We still need to talk coalition (2013). *We still need to talk: A report on access to talking therapies.* Available at https://www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf. Accessed on 20/02/20.

Whiteford, H., Buckingham, B., Harris, M., Diminic, S., Stockings, E., & Degenhardt, L. (2017). Estimating the number of adults with severe and persistent mental illness who have complex, multi-agency needs. *Australian and New Zealand Journal of Psychiatry, 51,* 799-809. https://doi.org/10.1177%2F0004867416683814

Williamson, E. (3rd October 2018). *[Psychologists in Hostels project]*. Greater Manchester Homeless Mental Health Conference, Manchester, UK. https://www.gmmh.nhs.uk/news/clinicians-from-across-the-uk-join-forces-to-tackle-mental-health-and-homelessness-2369/

> Psychotherapeutic interventions should be commissioned as a key part of local areas' responses to people experiencing severe and multiple disadvantage.

The University of Nottingham

Fulfilling Lives
South East Partnership

opportunity NOTTINGHAM
Believing in people. Inspiring change.

www.opportunitynottingham.co.uk
0115 850 4128
www.bht.org.uk/fulfilling-lives

COMMUNITY FUND