Evaluation of Sources of Support Service

SOS 100 Cases (2011/2014)

Interim Report

November 2015

The Scottish Government
Riaghaltas na h-Alba

EVALUATION OF SOURCES OF SUPPORT SERVICE

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INTERIM REPORT

CHRE

May 2015

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Lastly, sincere thanks to the local services in Dundee who formed the SOS referral pathway, thus supporting patients to address their needs. These services gave their time and insights to the evaluation, which was greatly appreciated. A full list of participating services and activities is detailed in the tables in Appendix 1. A glossary of services can be found at the back of this report to provide information on roles and remits of participating services where this may not have been apparent from the organisation's name.

Evaluation of Sources of Support Service: SOS 100 Cases 2011-2014

Executive Summary: May 2015

Background: The Sources of Support Service (SOS) was established by the Equally Well programme in Dundee to address the socio-economic and personal circumstances that affect patients' health and well-being, which GPs have neither the time, nor sometimes the necessary skills, to address. Three Link Workers with backgrounds in mental health and community development were appointed to work across four practices identified as having considerable numbers of deprived patients. The Link Workers used structured conversations of 40-50 mins duration to establish a rapport with patients and tease out the issues the patient wished to address. A plan of action would be created and the patient supported to access local services/activities to fulfill the plan. The Link Worker role sits within an asset based approach, working with people to develop their capacity and skills, and give them the confidence to act in a positive way to protect their well-being within the context in which they live.

Method: a case-based approach was used to provide an in-depth analysis of the work of the service and achievements thus far. There have been 656 referrals to the Sources of Support Service from its operational start at March 2011 to 31st Dec 2014. A purposive sample of 100 cases was chosen. The sample was structured to reflect patients that had completed their involvement with the service, and referral patterns across the four practices and each Link Worker. Three case based telephone interviews were held with each Link Worker who was provided with a pro-forma beforehand to facilitate the data collection. Each Link Worker had the relevant case files to hand to enable them to consult their notes and refresh their knowledge.

Sample Characteristics: 60% of cases were female and 40% male, almost identical to the gender balance within the TOTAL referrals to the SOS service as at end 2014. 71% of cases were aged 30-59 yrs (71), which was a higher percentage than the same range in ALL referrals (57%, 116). Thus, the age range of those who engaged and completed was narrower than the TOTAL of those referred to the service.

Statistical Overview:

- Link Workers averaged 3.1 consultations with each patient. 87% (86) of patients were moved through the service within the initial target of 4 consultations.
- Link Workers undertook supported visits to services/activities in 59 cases (156 supported visits in total); the average number of supported visits was 2.6 and the range 1-8.
- 272 goals were set by patients in concert with the Link Worker and of these 72% (195) were fully met, 13% (37) were partially met and 15% (40) were unmet. Forty five per cent (43) of patients had ALL their goals met. The main reasons patients did not meet their goals were: not turning up at the service/activity; deteriorating mental health; being overwhelmed by problems in their life at that moment.
- a wide variety of goal themes were addressed; the highest success rates (i.e. Yes, goal met) related to: finance (86% 34); housing (81% 22); work issues (79% 11); activities

(76% 27) and mental health (72% 34).

- 55% (50) of cases had their goals addressed using 2 or 3 services and a further 27% (25) of cases by 4 or 5 services. The main services utilised within the SOS 100 cases were: Insight Counselling, Making Money Work, Listening Service, Penumbra, Dundee Association for Mental Health (DAMH), Positive Steps, Connect and Remploy (See Glossary in Full Report).
- The most common combination of goal themes were: mental health and activities; mental health and finance; mental health, activities and health; mental health, finance and social isolation; housing, finance and health/mental health. The most common issues encompassed by the goals were: the effects of anxiety on day-to-day functioning, the effects of poor physical health (e.g. pain, mobility), lack of finance, lack of structure to the day, lack of ability/opportunities to socialise, and unsatisfactory housing for patient's needs.
- The main Link Worker roles within the goals were: facilitating (referrals; appointments) (73%, 204); information giving/research (43% 108); liaising (39%, 108) and support (including supported visits) (37%, 104). Just over three quarters (76%, 212) of all goals required between one and three Link Worker roles, the most common being a combination of facilitation, research/information, and support.

Barriers and Facilitators to Progress:

The barriers to addressing identified needs and the facilitators towards achieving positive patient outcomes were identified as follows:

- **Barriers:** anxiety (e.g. meeting new people, going out); low mood and lack of motivation; poor mobility and other physical limitations (especially pain as a result of physical issues); lack of money and resources (e.g. for travel, daily living); the lack of encouragement of those around the patient; lack of basic social skills (e.g. to deal with services); lack of time due to family/work commitments. Patients usually had multiple barriers e.g. a lack of money, poor mobility, ongoing pain and a lack of self-confidence/low mood.

- **Facilitators:** a supportive family; patient's own determination and motivation; the ability to listen and process information; an understanding employer; being able to drive and having a car. As with the barriers, the facilitators tended to work in tandem (e.g. the ability to take things on board, alongside the patient being determined and motivated, and having good family support).

Working on the Front-line: The Emerging Themes

There were five emergent themes relevant to implementation and achievement of patient outcomes within the SOS service: patient typologies; impact of family and friends; working with external services; the role of the Link Worker; 'some you win, some you don't'. Taking each in turn:

- **Patient Typologies**: six types of patient were identified through the evaluation: The 'Resistant' - not turning up at the external service/activity; declining

services/activities as not meeting their expectations, not bringing themselves to accept external help.
The 'Challenging' - underlying clinical issues (e.g. alcohol/drugs; notable memory issues; anger issues affecting their ability to interact with others in a reasonable manner; lack of social and negotiating skills).
The 'Vacillator' - once the process reached a point where they had to act, they used delaying tactics or did not turn up; the 'vacillators' would ask to stay with the service and promise the next time they would attend the external service/activity.
The 'Dependent' - clinging to the service as much for the psychological benefits (i.e. being listened to), as the practical benefits; dependency as an excuse to do nothing unless the Link Worker took charge.
The 'Focused' - strong notion of what they would like to get from the service; a strong focus within their lives that pushed them into taking action.
The 'Determined and Motivated' - may not have had an agenda but had an underlying 'can do' attitude; once pointed in the right direction, these patients acted independently, picking up and adapting ideas to suit their own circumstances.

- **Impact of Family and Friends**: acting as facilitators (accompanying the patient to services/activities; finding new things to do together; joining in with groups); acting as impediments (over protective parents/partners; unforeseen consequences of them attending service meetings); family as the focus (wanting to open up opportunities for the family/individual members; lowering family member's dependency on the patient; reconnecting/strengthening family relationships).

- **Working with External Services:** flexible service response (the value of services who could make home visits and/or meet with patients in their own locality); the service cascade (whereby the initial receiving service referred on to other appropriate services for the patient); one-stop shop (services with multiple components, capable of dealing with a broad range of issues, creating a pathway that moved the patient through their various specialty groups to a positive outcome); access issues (timing of available places; requirement to charge for a service; being with one type of service blocking access to other services; waiting lists; lack of provision per se); first impressions of the service (style of communication; not returning phone calls; not knowing/understanding the full story; staff with whom the patient made a connection leaving).

- **Role of the Link Worker*:*** tailored approach (ensuring that patients go to the right service for them, not just any service with a place available); joint working (e.g. carrying out joint visits with other services as appropriate; jointly working on finance/college applications, etc.; working together to facilitate discharging patients from SOS); making connections (between services and families; facilitating communication and information between services; clarity around respective roles); breaking the impasse (finding out what happened to applications; brokering communication and understanding between patients and services); plugging gaps and holding the fort (supporting the patient until the required service/professional became available); keeping it local (understanding what could be delivered where in relation to

a patient's practical circumstance and using their liaison and negotiating skills to put together the best local response as well as the best service fit); therapeutic underpinning (to gain trust by creating a safe environment; addressing behavioural issues that might prevent patients taking full advantage of SOS; using therapeutic techniques to calm patients when visiting services/activities).

- **A Reality Check:** the right service, the wrong moment (patients could experience a decline in their mental health that could act as a barrier to engagement just as opportunities opened up; a step back to go forward (e.g. addressing a basic skills gap/particular fears, might be the only way forward to achieving stated goals); you are never too old (the issues, solutions and potential benefits were similar across age groups).

Patient Asset/Skills Gains

Internal Assets/Skills Gains

- A greater awareness of services and how to access them
- A broader knowledge of what services are available
- The ability to access services for family members
- Sharing knowledge and skills with others
- Increased confidence and self-esteem (happier and taking charge of life)
- Developing a 'can do' attitude
- Seeing a future
- Ability to take/maximise opportunities
- More insight into their issues
- Knowing how to discuss issues calmly and positively
- Making their own decisions
- Wanting to go out and join in
- Specific self-help techniques (e.g. re pain control; SAD; Stress)

Practical External Gains

- Housing points
- Being rehoused (includes homeless)
- Internal house adaptations
- Furniture
- Improved employment conditions
- Change of employment/first job
- Volunteering training
- Volunteering post
- College course
- Qualification

- Literacy skills (including being able to draft a CV; fill in forms)
- Befriender
- More social contacts/new social networks
- Services for family members
- Opportunities to share own skills with others
- New interests/reconnect to previous interests
- Family activities
- Involvement in local community regeneration group

In Summary

The analysis of the SOS 100 cases highlighted the range and complexity of the work being undertaken. Even those patients who engaged and worked with the Link Workers were variously committed and provided a challenge to the Link Workers to keep them on board and moving forward. The Link Workers have gained a breadth and depth of knowledge of mainstream and community based services and activities that might well be unique within the service environment. Patients were not just setting goals but achieving them. In no small measure, this was due to a combination of the tenacity of the Link Workers and the developing good communication and joint working between the SOS service and other services.

1. Introduction

1.1 The Background to the Sources of Support Service

GPs have stated their concerns that 'many patients present with concerns that arise from their social situation, and the management of long-term medical conditions is often affected by personal circumstances'. (GPs at the Deep End Report 8 Social Prescribing, Sept 2010, University of Glasgow). They have pointed out that they have neither the time nor the necessary skills to deal with such problems. The Sources of Support Service had its origins in the national Equally Well programme. Within Dundee, the programme 'aimed to test new ways of working, predominately in public services, to tackle health inequalities and improve community mental well-being' (1). The Sources of Support Service was one of several initiatives set up and focused on 'strengthening access to sources of support for mental well-being in the community...'.[1].

1.2 The Sources of Support Service (SOS)

The service was provided to one practice during the pilot phase but this has now expanded to four practices across the City. Three experienced mental health and community development practitioners were recruited to the role of Link Worker and work across all four practices. The target group were patients affected by socio-economic, environmental and interpersonal issues that impacted on their mental well-being and referrals to the service came mainly from GPs and relevant practice staff (e.g. practice nurses). The link workers used structured conversations of 40-50mins duration to establish a rapport and develop a relationship with the patient. The conversational process teased out the issues the patient wished to address, the barriers to addressing the issues and the supports available (e.g. family, other services, patient's own resources). A collaborative plan of action was then created, and the patient linked to local services/activities to fulfill the plan. If necessary, the Link Worker would accompany the patient on service/activity visits. The Link Worker role sits within an assets-based approach, working with people to develop their capacity and skills and give them the confidence to act in a positive way to protect their own health within the context in which they live. The Link Workers work in a recovery focused manner with people and, by drawing on the

[1] Friedli Lynne, with Themessl-Huber Markus, and Butchart Maggie (2102) Evaluation of Dundee Equally Well Final Report

resources and insights of both patient and service providers, aim to create 'co-produced solutions' to problems.

1.3 Creating a Window on the Service

A case based approach has been used to provide a window on the work of the service and its achievements thus far. The case based approach has allowed a more in-depth analysis of the work of the service. The interim report presents the results of the analysis of a purposive sample of 100 cases that completed working with the Link Workers (see Section 2 Methodology). The report focuses on the following questions:

- Who were the patients?
- How did the service function in practice?
- Did the patients achieve their goals?
- What services were utilised to deliver patient goals?
- What role/s did the Link Workers play in helping the patient achieve their goals?
- What were the barriers and facilitators related to patients?
- What were the key themes emerging from working on the front-line?
- Where there assets/skills gains for the patients?

2 The Methodology

2.1 The Sample

There have been 656 referrals to the Sources of Support Service from its operational start at March 2011 to 31st Dec 2014. The cases reported represented a purposive sample of 100 cases that completed working with the Link Workers. The table below shows the distribution of the sample of referral/discharge sample:

SOS 100 Referral Year	SOS 100 Referral No of Cases	Discharge Year	SOS 100 Discharge No of Cases*
2011	10	2011	2
2012	10	2012	14
2013	41	2013	19
2014	39	2014	54
2015	0	2015	6
TOTAL	100		95

- Note 5 cases were still open as at end Jan 2015

80% of the SOS 100 completed cases were referred in 2013/14, with 73% of discharges taking place within the same time-frame.

In terms of the sample distribution between Link Workers and practices, the table below shows the sample construction - that is an equal number from each Link Worker and a practice distribution that reflects the practices the Link Workers had most commonly received their referrals from. Note that one practice had always referred more patients to the service than the other practices and that is reflected in the purposive sample.

Link Worker	**Practice 1**	**Practice 2**	**Practice 3**	**Practice 4**	**TOTAL**
LW1	4	12	9	8	33
LW2	0	9	16	9	34
LW3	11	0	22	0	32
TOTAL	**15**	**21**	**47**	**17**	**100**

2.2 Data Collection

The data collection mirrored the new SOS Excel data system providing more in-depth information on existing cases than previously held, particularly in relation to outcomes. It also ensured that the data for the cases the Link Workers worked with prior to this evaluation was maximised. Three case based telephone interviews were held with each Link Worker, who was provided with a pro-forma beforehand to facilitate the data collection. Each Link Worker had the relevant files to hand to enable them to consult their notes and refresh their knowledge.

2.3 Data Analysis and Presentation

The quantitative data (Tables can be found in Appendix 1) was analysed at the level of descriptive statistics and statistical significance (Confidence Intervals). As per statistical conventions, only those results that were significant would be reported. It should be noted that where the analysis related to the full 100 cases, the proportion would be identical to the number and therefore no percentage has been given. Where the analysis has been

undertaken on 95 or fewer cases, the key proportions have been given within the tables and highlighted by use of shading. In line with statistical convention, no proportions have been given for any values under ten with the exception of sub divisions where the value under ten is the main result (i.e. no values above ten). Key tables have been transformed into 'figures' to make it easier to follow the results. The qualitative data has been analysed with regard to emergent themes and each theme makes reference to specific case/s evidence.

3. SOS 100 Cases: Statistical Overview

It should be noted that initial engagement levels with the service have remained at a steady 70/71% (peak was 79% in 2013). That is, approximately one third of cases referred do not engage at all. Of those that do, a further 25% approximately drop out after initial engagement with the service. In the main these were females aged 20-29yrs and 40-49yrs. The reasons related to:

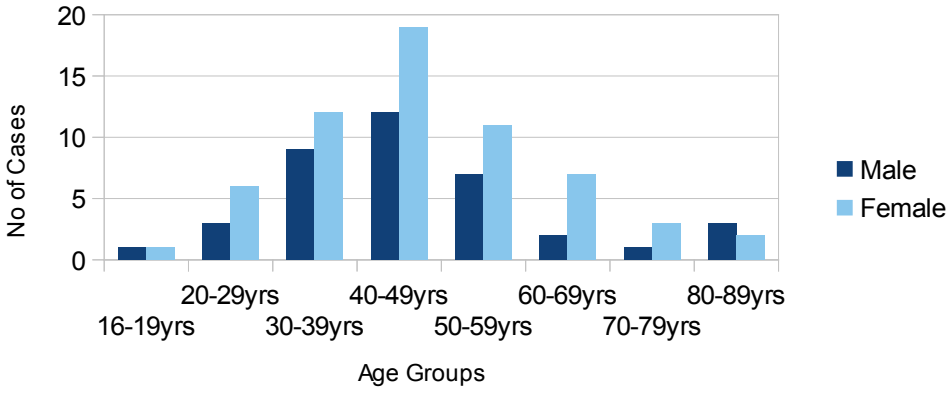
- issues arising in their lives such that they decide to drop out (the door was always held open to them returning at a later date).
- dropping out with no further contact and therefore no known reason.

3.1 Patient Characteristics (Table 1-3)

- 60% of cases were female and 40% male, which was almost identical to the gender balance within the TOTAL referrals to the SOS service. Thus, the 100 cases were gender representative of the data set as a whole (Table 1).

- 71% of the cases were aged 30-59yrs (71%). This was a higher percentage than the same range in ALL referrals (57%, 116). Thus the range who engaged in this sample was narrower than those who were referred (Table 1).

Figure 1: Gender by Age



- Just over two thirds (67%) of cases were unemployed (70% males; 65% females). Within this group, 61% (41) were unemployed due to being unfit to work/long-term sick. That represents 41% of the case study cases (Table 2).

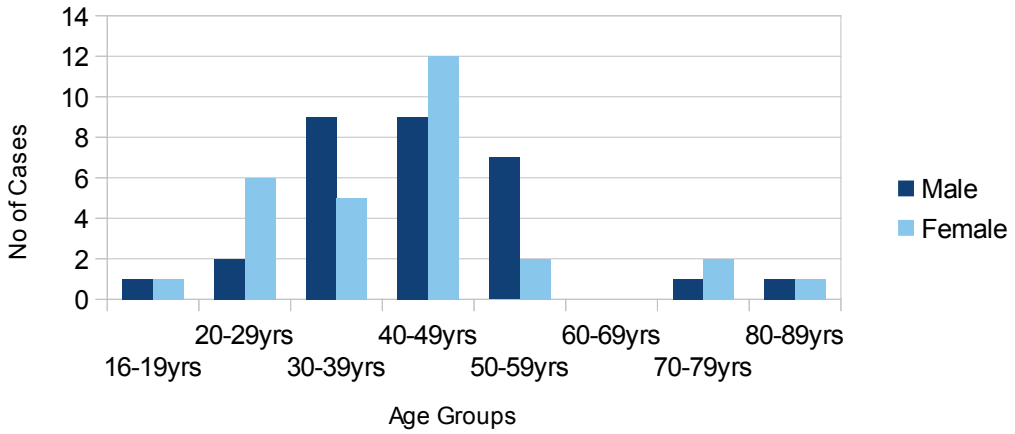
- 79% (79) of case patients were on benefits (72%, 29 of males; 83%, 50 of females). The main benefits were ESA, housing support and council tax (Table 3).

3.2 SOS Operational Outcomes (Tables 4-5)

The service had set an initial target of 4 consultations within which to work in collaboration with the patient to assess their needs, identify the barriers and facilitators to addressing their needs, set achievable goals and link the patient to the identified relevant services and or activities/learning opportunities. Table 4 shows that the Link Workers were averaging 3 consultations per patient and the majority of cases were dealt with within the 4 consultation target. The target of 4 consultations does not include any additional supported visits to services/ activities that were required.

Table 5.1 shows that over half the 100 sample cases (59) had received supported visits from the Link Workers, with an average of 2.6 visits per case. Just over half of those receiving supported visits were aged 30-49yrs (Table 5.2). Proportionately more females in the age range 40-49yrs received supported visits than males.

Figure 2: Supported Visits by Gender and Age



The 59 patients who received supported visits accessed 81 services. Not all accessed services required a supported visit thus, of the 81 services accessed, 79% (64) required supported visits (Table 5.3). It should be noted that the services generally have a similar pattern of supported visit usage with the exception of Dundee Healthy Living Initiative (DHLI) activities and Connect, where there are more cases with two visits than one visit. Three 'outlier' cases are worth noting:

- one case with 7 supported visits to an activity group: in this case, the complex health status of the patient, combined with a lack of locally appropriate services and transport, meant the Link Worker had to look further afield and organise supported visits to ensure the patient got access to an appropriate activity.
- one case with 4 supported visits to a drug and alcohol support organisation: here, the supported visits acknowledged the need to create a supported routine of going to the service, without which the patient's compliance might have been in doubt.
- one case with 4 supported visits to an activity group at a support organisation for people with mental health issues: this patient suffered from chronic anxiety re leaving home and going somewhere unfamiliar. Supported visits allowed a gradual exposure that helped the patient settle in a new environment with new people.

The outliers demonstrate both the need for flexibility on a case-by-case basis in the use of supported visits and the ability and willingness of the Link Workers to 'go the extra mile' to ensure patients could access the help they needed.

There were 38 cases (64%) where at least one goal was met without the need for a supported visit and just under half (44%, 81) of all goals set (185) were met without the need for a supported visit. Of the 21 cases with 3 or more supported visits, anxiety was a feature of the patient's mental health profile in 13 (62%). However, it was only identified as a possible 'barrier' to the patient addressing their issues in a third (7, 33%) of supported visit cases. It should be noted that anxiety as a referral issue was present in 48 cases out of the SOS 100 cases, with 16 individual cases where the Mental Health goal related directly to anxiety. The latter result was in part due to the anxiety being dealt with more indirectly through addressing other goals (e.g. social isolation, where the anxiety might be an underlying issue; finance, where the anxiety might be heightened by the lack of money, concerns re benefits). In nine cases patients had issues with leaving their homes and if mobility per se was added in then just over half (52%, 11) of patients with three or more supported visits had issues with leaving their homes.

3.3 SOS: Goal Outcomes (Tables 6-8)

Goals were set in concert with the patient and focused on the patient's agenda. An average of 2.8 goals were set per case, with a range of 1-8 goals (Table 6.1, 6.2). Nearly three quarters (72%, 195) of all goals were met and 85% of goals had some positive outcome (combining the partial and met categories). In overall terms, 45% (43) of patients had all their goals met by the service and 82% (78) of patients had two thirds or more of their goals met (Table 6.4). Only 7 patients had no goals met.

Figure 3: Goal Assessment

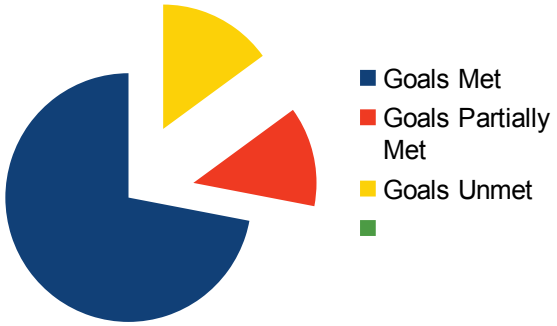
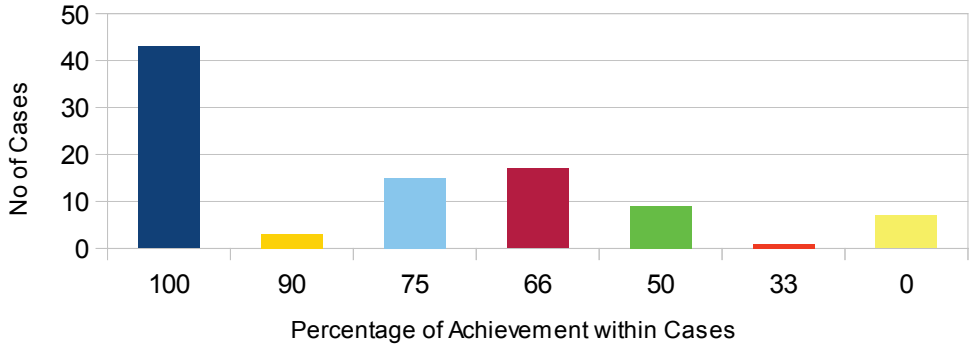


Figure 3a: Degree of Goal Achievement within Cases



The main reason patients failed to meet their goals was not turning up at the suggested service/activity (Table 6.3). Another notable reason was deterioration in the patient's mental health and beyond that - patients becoming overwhelmed by issues in their life. It should be noted that in some cases a negative cascade effect occurred (e.g. life events overwhelming a patient, leading to a deterioration of their mental state and therefore not turning up at services/activities).

The most common goal themes being addressed, in terms of individual cases, were mental health (e.g. low mood, depression, anxiety), activities, finance, physical health and social isolation (Table 7.1, Table 7.2). In terms of the number of goals set, the most common themes were the same with the addition of housing. In other words there were fewer cases where housing was a thematic per se, but where it was there tended to be more than one housing issue to address.

The SOS 100 cases produced a wide range of goal combinations, the most common of which were:

- mental health and activities; mental health and finance
- mental health, activities and health
- mental health, finance and social isolation
- housing, finance and health/mental health.

In terms of the actual issues the goals encompass then the most common issues were:

- effects of anxiety on day-to-day functioning
- effects of poor physical health (e.g. pain, mobility)
- lack of finance
- lack of structure to the day
- lack of ability/opportunities to socialise
- unsatisfactory housing re patient's needs.

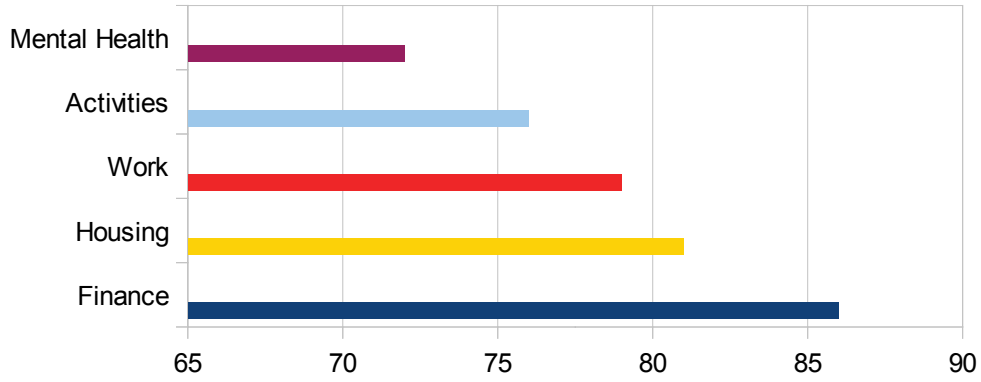
Cases were not just a combination of distinct goal thematics, for example mental health and finance, but had different issues to address within a thematic, as in one case where there were three health goals and a finance goal. 22% (22) of all SOS 100 cases had such combinations: finance, housing, health and mental health were the thematics most affected. For example, in one case there were three health related goals: support re stroke; help to reduce alcohol consumption; and help with self-care/eating. In another example there were three finance related goals: reconnecting gas supply; access to bedroom tax discretionary fund; and organising a benefits payments card. This indicates not just the complexity of the needs, but how one particular thematic within a case can be key to moving the patient's whole circumstances forward.

In order to look at the Goal Thematics v Goal Achievement the data was divided into two groups following statistical convention:

- Group A: those Goal Thematics where 10 or more goals were set
- Group B: those Goal Thematics where fewer than 10 goals had been set

Within Group A 70% or more goals were achieved in five thematic groups (Fig 3b). Within Group B three goal thematics (carer, skills/learning and other, e.g. food bank, travel issues etc.) returned the highest achievement (Table 7.3). Only two thematics fell below 50% achievement: bereavement and confidence/self-esteem (both largely as a result of patients not taking up the suggested services).

Figure 3b: Goal Thematic by Percentage Goals Achieved



In terms of Goal 1, (which might reasonably be seen as the most pressing need) the common themes were mental health, activities and social isolation. Over three quarters of first goals were met and within that 100% of the goals related to 'activities' were met. (Table 7.4).

3.4 Service Pathways (Tables 8-10)

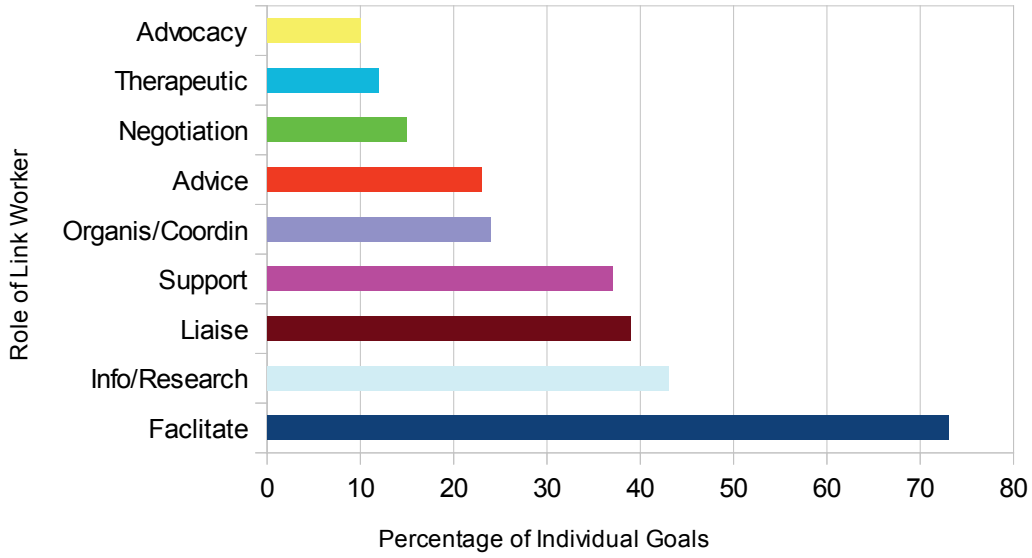
A wide range of services were being accessed to address patient goals but in reality 55% (50) of patients had their goals addressed by accessing 2 or 3 services (Table 8, Table 8.1, Table 9). A further 27% (25) of patients had their goals addressed by accessing 4 or 5 services. In part, the results reflected the fact that a number of services were providing multi-issue solutions e.g. DAMH, Penumbra, Connect, Positive Steps, Remploy, Youth Literacy Team. For example, DAMH creates an umbrella for different projects and provides everything from support groups to activities, to befriending. Thus, in one case the patient started at the 'drop-in' and graduated to the music group and befriender service. The most commonly accessed services related to counselling, finance, activities, housing and employment (Table 10.1, Table 9.2).

3.5 The Role of the Link Worker (Table 10.1 10.2)

The Link Workers undertook a variety of roles within the 100 sample cases beyond the initial collaborative identification of issues to address (Table 10.1). The principle role was that of facilitating the patient's 'goal/s', by suggesting services and groups that could potentially meet their needs; referring the patient to the relevant service/activity and making any necessary appointments. The patient chooses the services/activities they wish to engage with, not the Link Worker. The second major role was providing information to the patient on services/activities and, allied to that, researching new services. This was followed by liaising with services and supporting the patient to access the service.

Just over three quarters (76%, 212 goals) of all goals required between one and three Link Worker roles (Table 11.1), the most common being a combination of facilitation, research/information and support (Table 10.2). Section 5 of the Interim Report expands on the role of the link worker both at case level and within the wider service environment.

Figure 4: Role of the Link Workers in Individual Goals



4. Barriers and Facilitators to Patients Addressing Their Own Issues

Each patient brought with them aspects of their personality; family and socio-economic circumstances that could impact on their ability to work with the SOS service, address their issues, and accept and make the best use of the advice on services/activities available. That in turn affected the degree of progress they could make and sustain longer term.

4.1 Barriers to Addressing Issues

Anxiety was one of the main barriers to patients seeking and taking up offers of help. The idea of mixing with other people could bring on panic attacks and prevented some patients leaving the house. Low mood and lack of motivation meant that patients struggled to see a way forward out of their difficulties. Poor mobility and other physical limitations could result in reluctance to leave the house because of the effort involved, particularly if the patient was in pain as a result of physical issues. Lack of money and resources was another barrier, especially if the patient had to travel to appointments. The lack of encouragement of those around the patient could be enough, in concert with other factors, to prevent the patient making efforts to address their issues and/or seek help. Some patients lacked basic social skills to enable them to interact successfully with services whilst others had behavioural issues which had the same negative effect. Lack of time due to family/work commitments was a barrier, as was commuting distance to services providing help. Patients usually had multiple barriers, for example, lack of money, poor mobility, ongoing pain and lack of self-confidence/low mood. The more barriers, and the more entrenched the barriers were, the greater the difficulty in breaking the negative cycle. Appointments would be planned between the patient, the Link Worker and the receiving service/group to work around barriers:

- if mornings were difficult for some patients (e.g. due to the effects of medication) then the appointment would be planned for the afternoon
- when working with parents, appointments were set so as not to clash with the school run or other family duties
- where patients found it difficult to leave the house, local venues near their home were used if possible

4.2 Facilitators

The key facilitator was a supportive family who could provide a positive reason for a patient addressing their issues and practical help such as taking the patient to appointments. Being able to drive and having a car took away one of the potential barriers to action. Another important facilitator was the ability of the patient to listen and process information. Having an understanding employer took the stress out of having to ask for time off to attend appointments, and employers could just as easily be a barrier to progress if they were not supportive of their employee. As with barriers, facilitators tended to work in tandem, for example, ability to take things on board, alongside the patient being determined and motivated, and having good family support.

5. Working on the Front-line: The Emerging Themes

Analysis of the SOS 100 cases highlighted a number of themes that illustrated the reality for the link workers in working with patients with complex factors affecting their well-being, and the positive and negative factors affecting progress.

5.1 Patient Typologies

At the heart of the SOS service was the patient. From the case analysis, six broad patient profiles can be suggested: the 'resistant', the 'challenging', the 'vacillator', the ‘dependent’, the 'focused', and the 'determined and motivated'. Taking each in turn:

5.1.1 The 'Resistant': within this group, 'resistance' manifests itself in different ways. For some patients, no matter what was organised by way of external help, they did not turn up at the external service/activity and, more often than not, disengaged from the SOS service itself. Other patients declined services/activities as not meeting their expectations, whilst a subset of this category could not accept external help. This 'resistant' patient created a dilemma for the Link Workers in deciding how far to persist, both in their own efforts to get the patient the necessary help, and being mindful of the impact on external services of patients not turning up or eventually turning down help. Initially the Link Workers tried to persist with such patients, setting new service appointments, but over time they came to realise that there were limits on the value of that strategy and had latterly taken a more pragmatic stand based on

their accumulating experience with such patients. If the patient came with a known history of missing appointments with the GP and previous services, this could perhaps be considered a 'warning bell' in the future as to their potential behaviour with the service. At this moment the Link Workers do not have access to this information and it might be worth considering whether to flag this issue up in the referral from GP to Link Worker. Similarly, patients habitually missing/postponing their initial consultations with the Link Worker could be seen as a red flag in terms of willingness to engage with external services.

5.1.2 The 'Challenging': while it could be argued that all SOS patients were challenging to some degree or other, there were instances of patients whose behaviour and/or underlying clinical issues created particular challenges in terms of their ability to work with the SOS service. Patients with an underlying addiction issue (be that drugs or alcohol) could prove somewhat unreliable at keeping appointments, not out of any overt resistance to the SOS service and any external help offered, but through chaotic lifestyles impacting on ability to remember and take action. Difficulties in keeping appointments sometimes also applied to patients with memory issues. Both types of patient required ongoing prompting to get them to appointments or to be picked up and taken to appointments. External services trying to work with such patients faced the same difficulties, often resulting in such patients being discharged from the service for failing to turn up to appointments, or not being at home when staff called. That was not to say the external service did not make efforts to engage with the patient, but there were limits to this. Another type of challenging patient was those whose behaviour gave cause for concern in terms of their ability to interact with others in what could be deemed a reasonable manner - for example, patients whose levels of anger dominated their behaviour making it necessary to address that issue before trying to address others. Services raising this with the patient sometimes created a reality check that, in some cases, allowed them to accept specialist help. The opposite challenge was that of patients whose over-enthusiasm, and lack of social and negotiating skills, left a trail of failed attempts to get help and a reputation for being 'difficult'. In these instances, the Link Workers were left with a delicate task of reconnecting patients to services, whilst reassuring these services that the patient did now understand the need to listen to what was being suggested.

5.1.3 The 'Vacillator': on the surface these patients engaged with the service, but once the process reached a point where they had to act the tendency was to use what could be defined as delaying tactics - for example, cancelling or rescheduling appointments, making themselves unavailable or not turning up. This group understood they needed help but for a variety of reasons could not make the next step, even if the Link Workers offered to accompany them to a service/activity. What distinguished this group from the 'resistant' group was their reaction to the possibility of being discharged from the service. The 'vacillators' would ask to stay with the service and promise that the next time they would act on the advice or attend the external service/activity. On occasion, a family member would intervene and ask the Link Workers to give the patient another chance. In many ways this 'vacillator' group was more difficult to deal with than the 'resistant' group, as the underlying pressure was to give them that second or third chance in recognition that some patients required time to come to terms with what they themselves needed to do to improve their situation and to take responsibility. Initially, this type of vacillating behaviour left the Link Workers on the cusp of discharging patients then reversing the decision and more often than not finding themselves in a similar position a few weeks down the line. Latterly the Link Workers had, on identifying such patterns of behaviour, taken a stronger line and discharged such patients after two/three vacillating events, while at the same time pointing out the service would welcome the patient back in the future. It should be noted that for some patients the suggestion of being discharged from the service was enough to galvanise them into taking the advice/action they had previously agreed.

5.1.4 The 'Dependent': the key strength of the Link Workers in creating strong working relationships with the patients could also work against the service if patients became too comfortable and/or did not have the confidence to let go. For many patients the Link Worker (as evidenced by the patient feedback comments) represented the first person who gave them time, listened, and worked across their needs to create a coherent achievable plan. The temptation for some patients was to try and cling to the service even if their initial needs were met, perhaps as much for the psychological and therapeutic benefits as the practical benefits. In other patients the dependency behaviour could become an excuse to do nothing -for example, unless the Link Worker went with them/took them to a service/activity they would

not go. Weaning people off the service took as much skill as engaging the patient with the service.

5.1.5 'The Focused': this group of patients had a strong notion of what they would like to get from the service In addition, some of these patients had a strong focus within their lives that pushed them into taking action (e.g. children and partners or a life event that highlighted the need for change). Some patients were focused on improving/strengthening relationships within their lives, re-engaging with family and friends, and putting their lives on a more positive track. Others were focused on very specific practical issues such as moving house, getting employment/more suitable employment, reconnecting with past interests and/or getting involved with new interests. For these patients, the SOS service was a way of accessing information and help to achieve their goals.

5.1.6 'The Determined and Motivated': these patients came into the process with or without a clear agenda to address but with an underlying 'can do' attitude that the Link Workers could harness to achieve progress. These patients might still require support to initially interact with services/activities but the support was limited and, in general, once pointed in the right direction these patients acted independently and were often difficult to follow-up because they were so busy and out all the time. In other instances patients began to use the ideas they picked up from the SOS service (e.g. setting up a creative room within the family home to improve the quality of interaction with the children). Even patients who initially appeared anxious and lacking in confidence could find reserves of determination when they felt they had support, and could achieve major changes in their lives through their own actions - for example, being assertive with employers and negotiating better working conditions and/or moves into less stressful work and even changing careers. That type of success could reinforce motivation and determination in dealing with other aspects of their lives. Drawing out and supporting these reserves was critical to the degree of progress within a case.

5.2. The Impact of and on Family and Friends

In one fifth (20) of the cases, family and friends played a role. They acted as facilitators or impediments to progress and were the focus of the goals the patient set.

5.2.1 Family/Friends as a Facilitator: one of the key ways in which family/friends assisted progress was in going along to activities/courses with the patient. Not only did this ensure the patient attended, it provided a familiar supportive presence when walking into a new place for the first time. Within relationships opportunities were being created to share interests, old and new, and through that encouraging families and friends to do more together. For example, in one case the husband of a patient did the groundwork for them both to attend a college course that he was equally interested in. In another case the patient and daughter attended a counselling course together: although it was meant for the patient, the daughter felt they too would benefit, particularly in understanding the issues their parent was facing and the strategies that might help them cope. There was one instance of an economic exchange within a family whereby the patient was paid to undertake some childcare to allow another family member to go out to work. Given that the patient had been looking for something to occupy her time it was a 'win-win' situation for the family as a whole. The importance of the family/friends role was not only that of emotional support and verbal encouragement, but practical support of 'going and doing' with the patient.

5.2.2 Families as an Impediment: not all family relationships worked in the patient's favour. In some cases over-protective parents could have a negative effect. Breaking the dependency cycle was not easy and working with the SOS service provided one way of opening these issues and exploring options. In one case the patient was supported to get rehoused in their own tenancy. Living independently encouraged a less dependent relationship with the parent such that the patient was now doing things of their own accord. As noted earlier, families going with the patient to services/activities could be very positive, but in other instances it could have unfortunate consequences. For example, when the parents of one patient attended an external service meeting the effect was to discourage the patient from speaking and the impression was left that the patient had their housing needs covered and therefore there was no role for the external service. In that particular case the housing issues were eventually sorted without any further intervention from the patient's parents.

5.2.3 Families as the Focus: it was notable that some patients used the SOS service to get help/open up opportunities for family members. For example, one patient suspected their child had specific behavioural difficulties but the service professionals they dealt with disagreed leaving the patient frustrated and not knowing where to go for help. The Link Worker made the appropriate clinical service connections; the child was diagnosed as having specific behavioural difficulties, and help and advice was provided to the patient and their child. Through the Link Workers other patients got help for family members in relation to mental illness, dyslexia and weight issues. In other examples the family help being sought was linked more directly to lowering the levels of stress in the patient's life (e.g. helping a partner find activities to do on their own and lowering the dependency on the patient to go and do things with them; linking a daughter to a service to give the patient some 'me time' and the daughter something positive to do with her time. Indeed, the latter linkage was so successful, the daughter ended up with a job at the service). Patients were also looking for activities that could be done as a family unit by way of strengthening that relationship or, where families were separated, reconnecting in a positive way. For example, linking one patient to the Active Families service resulted in an overweight family getting active together and trying new things; they now cycle and swim - activities they had never done before. However, this focus on the family could also work against dealing with the patient's own issues (e.g. the grandmother who decided not to continue with the SOS service at the time in order to give her grandson her full attention as he had just moved in with her and had yet to settle).

5.3 Working with External Services

In large part the ability of the SOS service to fulfill its brief was dependent on the range of, and access to, external services and the ability of these services to respond to the needs of the SOS patients.

5.3.1 Flexible Service Response: the degree of flexibility of external services impacted on what could be achieved for SOS patients. Some patients' levels of anxiety were such that they would not travel to a service even with the support of the Link Worker. Other patients were unwilling or anxious about leaving their local area. Those with family commitments could find it difficult to agree to meetings outwith their local area, particularly if they had no

access to a car and were reliant on public transport. Having access to relevant services that could make home visits and/or meet with patients in their own locality got round what could have been an insurmountable barrier to getting help. Services such as Making Money Work would do home visits, while others such as the Listening Service and Penumbra would come to a local community setting to meet the patient. In addition, seeing the patient in their own environment could give valuable insight into their needs and the impact of the 'home'/'local' environment as a facilitator or impediment to addressing these needs. Those patients who worked shifts found it difficult to fit in with services - that is, the time they were available might not be the time the service could give, so any flexibility in time/location/venue was crucial to engagement.

5.3.2 The Service Cascade: the 'cascade' operates at formal and informal levels. An example of the former was a referral to a money service that led to a referral to an energy saving service. In other instances referrals to 'umbrella' organisations with multiple sub-divisions led to an internal cascade (e.g. some mental health support organisations offer drop-in services that can then lead to clients moving onto activity groups). In general the Link Workers noted how helpful some external services could be in this respect (i.e. redirecting the original SOS referral to a more appropriate service/'group'). Not only did it mean the patient getting the right help, it built on the Link Worker's knowledge and refined their use of the services. The Link Workers refer in the knowledge that, if appropriate, a suitable 'cascade' for their patient will happen within multi-provision services. An example of the informal 'cascade' was a patient attending an adult literacy class who got talking to the worker running the class and learned about a local walking group; the patient subsequently joined the walking group.

5.3.3 The One-Stop Shop: many of the external services might look as though they are single issue services but this was far from the case. Within their remit they were capable of dealing with a broad range of issues and creating a pathway that moved the patient through the service to a positive outcome. In the following example one external service (DCC Youth Literacy Team) working with the Link Worker successfully addressed a patient's multiple goals. The patient was socially isolated with mental health and literacy issues, little family support, and was generally struggling with life, but they knew what they wanted in this case

to get a place in college and/or a job. They set goals with the Link Worker of structuring their day, improving their literacy, engaging in activities to improve their social skills, and getting a place in college and/or a job. Attending the Youth Literacy Team brought structure to the week; the patient was given 1:1 support to address literacy issues; they got involved in group activities provided by the Youth Literacy Team, including a bus ticket to facilitate travelling to venues; they were helped to make applications to college and for a job in the care sector, which the patient subsequently got. The Link Worker worked in tandem, prepared the ground with therapeutic support to the patient, negotiated with the Youth Literacy team, provided support visits to ease the patient into the Team, researched courses and helped with references. One external service with multiple relevant roles, one Link Worker, a focused, determined patient and four goals successfully achieved.

5.3.4 Access Issues: from the case analysis, five issues emerged:

- First, even when the Link Worker found a service or course for a patient, there was no guarantee these would go ahead, would complete, or would exist by the time the patient got a place or was ready to take up an offer. In eight cases one of these issues occurred: in three cases the service folded either just before or shortly after the patient was due to attend. In the remaining five cases, the course was either cancelled at the outset or cancelled midway through due to a lack of people attending.
- Second, not every service was free to every patient: some services were required to charge for their services or access was means tested. This could create problems, particularly if the patient had started working with the service before a decision had been made regarding charges. In one such case it had been hoped that due to the patient's circumstances the charges would be waived, but this did not happen and the patient had to temporarily leave the service with a debt for the use of the service to date. Liaison between the Link Worker, the service, and the department concerned resolved the matter and the accumulated debt was waived. In another case a patient was unable to attend a course as there was a charge and no obvious source of funding assistance. Some patients do not have the money to travel to services/activities and in one case the Link Worker raised the travel funds from another source. It should be

noted that some patients were actively asking for low cost or no cost activities as they did not have the ability to pay.

- Third, attendance at one type of service/course blocked access to other services. For example, patients on methadone programmes were excluded from accessing some services. Being on a Benefits related course could make it difficult to access other job support because of the tight rules surrounding its implementation. Indeed, and as one case illustrated, trying to step back from such courses to take advantage of other employment advice/opportunities was extremely difficult and, in that instance, required the help of the local MP to open a way forward.
- Fourth, and unsurprisingly, there were waiting lists for some services, particularly those related to counselling and befriending, and not only as a result of lack of staff, but also as a result of 1:1 matching systems (no matter how appropriate), and therefore who was available when. In one instance the delay was due to trying to get a group of volunteers together that could work with a particular group of people and their needs.
- Last, the Link Workers highlighted what appeared to be actual service gaps during the time period of the case study (2013/2014). One related to help for families of offenders: there was a telephone helpline but, at the time of need, no local support group could be found. Similarly, at the time, there appeared to be a lack of 'open access' support groups for patients with post-traumatic stress syndrome.

5.3.5 First Impressions: how services presented and communicated with patients could have an impact on the patient's mood and willingness to co-operate. For example, letters related to benefits issues caused much angst leading to some patients withdrawing from all services, one patient contemplating suicide, and another refusing to take up a volunteer role for fear of losing their existing benefits. The Link Workers were able to address these issues by reconnecting the patient to services; advising GPs of the 'suicidal thoughts' of another patient (where there was a risk to life); and getting advice to the patient who feared their benefits would be cut. Patients could be fragile in terms of their dealings with external services, thus a service not returning a call meant one patient stated he did not want to deal with them despite the potential help on offer. Another patient found the telephone manner of a worker so off-putting they would not consider going to the service. The lack of in-depth knowledge of a

patient's circumstances occasionally resulted in services making erroneous assumptions about the patient's willingness to accept help. In some cases the Link Worker was able to provide background information that resulted in a more understanding attitude, but in other cases the background reasons were so delicate and personal that it presented a real dilemma as to whether the information should be shared. Lastly, first impressions can be so positive that if a worker leaves a service/group the patient may decide not to continue, as happened in another case.

5.4 The Role of the Link Worker

As noted earlier in the report, the Link Workers had a wide variety of roles within cases, and rarely did a case require one role. Underlying the common roles was the ongoing encouragement and prompting to ensure patients attended the service/activity on offer. The case analysis also highlighted seven broad roles that underpinned the achievement of patient goals and created a strong and positive link worker presence within the City's service environment.

5.4.1 The 'Tailored' Approach: the cases highlight the efforts the Link Workers make to ensure that the patients got to the right service for them. This was not simplistic matching of needs to a service, but a carefully considered plan emerging from the consultation process. For example, there were different 'issue-based' counselling services available and differing styles of befriending services. The Link Workers were not only looking at service availability and patient needs, but who the patient was in terms of personality, their past experiences, and their present state of functioning (mental and physical). The Link Workers were using their accumulated knowledge of the various services and how they operated to make the best match for the patient. For example, in one case understanding the nature of the patient's social isolation was critical in deciding between one organisation, which promotes recovery focused support with individuals to improve their mental health and well-being, including integrating people back into the community by taking them out to activities, and another, which provides a listening ear. The patient might have been perceived by professionals as socially isolated but was quite content with that state and not looking to interact more widely with people. What the patient wanted was someone on whom they could unburden their

worries and the Link Worker referral was made with this in mind. In another case the behaviour of the patient determined which service could be accessed: one service may have had difficulties with the patient's behaviour whereas the other service option was well versed in challenging behaviour. The Link Workers would use the past experience of patients to ensure the right fit. However, a challenging past experience with a service did not necessarily mean the service could not be accessed - it depended on the nature of the experience and the extent to which the Link Workers could inform, advocate and negotiate to ensure the right conditions for that patient on this occasion. Where issues of trust were a key feature in a case, the Link Workers were careful to ensure the receiving service understood this and acted accordingly.

5.4.2 'Joint Working/Team Working': analysis of the cases highlighted four types of working:

- First, where the referring service does preparatory work using their own knowledge of, and access to, services before handing over to the Link Worker. For example, in one case a GP organised the Health and Homeless Outreach Team to address an immediate crisis in a patient's life, before then referring on to the SOS service. By stabilising the patient's accommodation the GP was able to focus the referral and facilitate the Link Worker's role. A variation on this type of working was where the Link Worker referred patients back to the GP as the gatekeeper to mental health services (e.g. accessing the Health Psychologist) and/or to have their medication reviewed.
- Second, where the Link Worker and the external service work in tandem to address an issue (e.g. the external service (Connect) helped the patient complete the Attendance Allowance form and the Link Worker provided the supporting statement).
- Third, where the Link Worker facilitates another service's ability to do home visits and that, in turn, enables the SOS patient to have their specific needs assessed. For example, where the service visit required two people but only one staff member was available at the time of the appointment the Link Worker might attend in their absence. The Link Worker would also attend (as appropriate) just to introduce and facilitate the first meeting between the patient and receiving service as a way of strengthening the chances of engagement.
- Last, by working closely together it was possible to discharge patients that might

otherwise have been held by the SOS service. For example, in cases where the level of support being provided by the external service was sufficient to allow an agreed discharge from the SOS service.

5.4.3 Making Connections: on occasion the Link Worker acted as an 'advocate' between a service and a family where communication had not been properly established or had broken down. In one such case the Link Worker (with the patient's permission) reassured the parent and created a link to the patient's befriender where none had existed. A similar role was making connections between services in a case: for example connecting social work and the health visitor so that each party knew what was happening and both could update the Link Worker on the key aspects of the case from their service's point of view. Last, making connections to ensure there was clarity regarding the Link Worker role and no duplication of effort between the Link Worker and other services in a case. This was particularly important where there might be lengthy waiting times for an external service and the Link Worker continued to offer practical and therapeutic support to ensure that the patient stayed engaged until the receiving service had an opening.

5.4.4 Breaking the Impasse: there were examples of cases where the role of the Link Worker focused on finding out what had happened to applications for different types of Benefits. In one such case a benefits appeal had not been actioned with seemingly no-one assigned to addressing the matter. The patient's levels of distress were such that their ability to cope and function were severely impaired. With the withdrawal date of the benefit drawing close and all other avenues of help exhausted, the Link Worker (in concert with another service supporting the patient) got the local MSP involved and the issue was resolved within two weeks. In another case the Link Worker accompanied a patient with severe mental health issues to a meeting with an employment lawyer to try and find out what was happening to resolve work issues that had led to the patient going 'off sick' and living under the threat of dismissal from the company. The Link Worker's presence not only addressed the impasse, but crucially ensured that the patient understood what was being said and took necessary action. The Link Worker then involved Remploy and they provided support to the patient to look for alternative employment. The Link Worker managed to find a volunteer post for the patient and

Remploy continue to support the patient to find a more permanent post.

5.4.5 Plugging Gaps and Holding the Fort: as previously mentioned, it was not always possible to get the required service at the required time, and in some cases the Link Workers supported the patient until the service became available. The alternative was to risk losing the patient and/or the progress they had made. For example, Link Workers offered therapeutic support while patients waited for counselling services. Where community cars were unavailable, at times, Link Workers took older patients to community activities until alternative arrangements could be made. In another case, the Link Worker stayed involved until an advocacy worker could be appointed. External services were very appreciative of the Link Workers support and joint working but on occasion that could spill over into trying to keep the SOS service involved when it was unrealistic to do so.

5.4.6 Keeping It Local: the Link Workers had not constructed a simplistic rote knowledge of the available services, but had built (and continue to build) a sophisticated understanding of what could be delivered where in relation to a patient's practical circumstances. The Link Workers used their liaison and negotiating skills to put together the best local response, as well as the best service fit. For some patients keeping it local was crucial to engaging with external services and activities. Some patients lacked confidence to leave their neighbourhood; in some cases it was fear for their personal safety if they were seen in other areas of the City; for other patients, family commitments (including childcare) constrained both the time and place of engagement. If the external service was flexible enough then local community centres provided a good option for engagement, as well as sources of local activities. As patients grew in confidence, some began to range beyond their comfort zone (e.g. one patient started going to art classes that required taking a local bus in another area of Dundee, something the patient would not have done on their own before working with the SOS service).

5.4.7 The Therapeutic Underpinning: the Link Worker role was not designed to be therapeutic in a clinical sense, but this aspect of the work has underpinned much of the case work, particularly through the initial consultation phase. All three Link Workers are qualified

counsellors. The Link Workers used their therapeutic skills to support the clients to deal with strong emotional responses and find strategies to work with these emotions and any attached behaviours. Three basic uses emerged: first, getting patients to trust in the service, relax and open up to the Link Worker. The Link Workers did this by building a rapport and creating a safe environment in which the client could explore sensitive and emotive issues and concerns. Second, helping the patient address behavioural issues and other deep seated issues that might prevent them taking full advantage of the SOS service, and any external services/activities on offer. The Link Workers did this by working on issues such as creating routines, structure and purpose to the day, looking at self-care, sleeping and eating patterns, and use of medication. Third, applying therapeutic techniques on external service/activity visits to calm the patient and help them deal with new people and new situations. The Link Workers did this by working through the patient's symptoms of anxiety and helping them prevent/deal with panic and fear. Changes in the way that health inequalities organisations operate in Dundee provided an opportunity to appoint a therapeutic support link worker to the SOS service on a temporary basis. This was intended to provide a more structured approach to dealing with those patients whose levels of stress and anxiety and general behaviour required a more intensive intervention. To date 33 referrals have been made by the Link Workers and 22 patients have engaged at some level with the SOS Therapeutic Worker. The goals set by the SOS Therapeutic Worker link to the goals set by the Patient with the Link Worker.

5.5 A Reality Check

The analysis of the 100 cases suggests the Link Workers had a notable success rate in achieving patients goals provided the patients worked with the service and took on board the advice and help on offer. As noted earlier in the report, few patients who engaged with the service left without at least one positive intervention.

5.5.1 The Right Service, the Wrong Moment: not all patients were in a frame of mind that allowed them to work with the Link Workers. Some were so overwhelmed by the issues in their lives that levels of stress and anxiety had to be brought under control before a meaningful conversation could occur. In one such case the Link Worker made an immediate

referral to the Therapeutic Worker to work on the patient's distress and provide them with strategies that would allow them to cope better and re-engage with the Link Worker. In another case a patient felt too anxious to attend a confidence building course at the time the course was starting and wanted to leave it for another time when they felt better. Patients with depression and low mood could experience a decline in their mental health which could act as a barrier to engaging with others just as opportunities opened up. Part of the Link Worker's skill lay in judging when to give patients time and space to decide if it was the right time to engage with a particular service/activity.

5.5.2 A Step Back to Go Forward: the Link Workers recognised that a clinical review of the patient's medication could be as helpful as matching the patient to another service, particularly patients with low mood, depression and anxiety. Counselling or other support services were not always the answer and a review of the patient's medication might be more appropriate, especially if it helped manage the patient's symptoms and allowed them to take advantage of the support on offer. In another case the Link Worker organised a bowel screening for a patient who was so fixated on the fear of bowel cancer that no progress could be made until that issue was addressed. Some patients had underlying literacy issues which prevented them accessing services unless helped by a family member/friend (i.e. reading and completing application forms). Going one step back and addressing a basic skills gap might be the only way forward to achieving their stated goals.

5.5.3 You Are Never Too Old: there were few patients aged 80yrs and over in the case study group (and the service in general). The issues those cases presented were indicative of the other age groups within the SOS service, and the services used and benefits gained similarly. One patient set three goals - two were met and one partially met. This included finding a service to listen to their side of the 'move to sheltered housing' the family was trying to achieve for the patient and work through their feelings. The patient's alcohol use had reduced due, in par,t to physical issues, but also due to resolving the issues surrounding the move to sheltered housing. Lastly, the patient's depression and low mood began to lift.

6. Patient Asset/Skills Gains

This section lists the range of assets/skills gained by the patients: first, the gains to the patient in terms of their own internal asset/skills base; and second, practical external gains.

Internal Assets/Skills Gains

A greater awareness of services and how to access them
A broader knowledge of what services are available
The ability to access services for family members
Sharing knowledge and skills with others
Increased confidence and self-esteem (happier and taking charge of life)
Developing a 'can do' attitude
Seeing a future
Ability to take/maximise opportunities
More insight into issues
Knowing how to discuss issues calmly and positively
Making their own decisions
Wanting to go out and join in
Specific self-help techniques (e.g. re pain control; SAD; Stress)

Practical External Gains

Housing points
Rehoused (includes homeless)
Internal adaptations
Furniture
Improved employment conditions
Change of employment/first job
Volunteering training
Volunteering post
College course
Qualification
Literacy skills (including being able to draft a CV; fill in forms)

Befriender
More social contacts/new social networks
Services for family members
Opportunities to share own skills with others
New interests/reconnect to previous interests
Family activities
Involvement in local community regeneration group

In Summary

The analysis of the SOS 100 cases highlighted the range and complexity of the work being undertaken. Even those patients who engaged and worked with the Link Workers were variously committed and provided a challenge to the Link Workers to keep them on board and moving forward. The Link Workers have gained a breadth and depth of knowledge of mainstream and community based services and activities that might well be unique within the service environment. Patients were not only setting goals but achieving them. In no small measure this was due to a combination of the tenacity of the Link Workers and developing good communication and joint working between the SOS service and other external services/activities. Patients improved their knowledge and skills base and at the same time some patients gained very practical, very tangible 'benefits'.

APPENDIX 1: TABLES

Table 1: SOS 100: Age by Gender

	Male	Female	TOTAL
16-19yrs	1	1	**2**
20-29yrs	3	6	**9**
30-39yrs	9	12	**21**
40-49yrs	12 (32%)	19 (31%)	**31 (31%)**
50-59yrs	7	11	**18**
60-69yrs	2	7	**9**
70-79yrs	1	3	**4**
80-89yrs	3	2	**5**
TOTAL	**38**	**61**	**99**

Table 2: SOS 100: Employment Status by Gender

	Male	Female	TOTAL
Employed F/T	5	4	**9**
Employed P/T	3	7	**10**
Self Employed	1	0	**1**
Unemployed	12 (30%)	14 (23%)	**26**
Unemployed LTS Unfit for Work	16 (40%)	25 (42%)	**41**
Student	0	1	**1**
Retired	3	9	**12**
TOTAL	**40**	**60**	**100**

Table 3: SOS 100: No of Patients On Benefits by Gender

	Male	Female	TOTAL
Yes*	29 (72%)	50 (83%)	**79**
No	11	10	**21**
TOTAL	**40**	**60**	**100**

* includes 13 retired people on state pension

Table 4: SOS 100: No of Face to Face Consultations (N=99 Cases)*

Total Face to Face Consultations	Average No Per Case	No of Cases where <=4	No of Cases where >4
304	3.1	86 (87%)	13 (13%)

*1 case no face to face consultation

Table 5.1: SOS 100: Support Visits*: Summary Table*

No of Cases	No of Support Visits	Range: No of Support Visits	Average Support Visits per case	>3 Support visits	=/>5 Support visits
59	156	1 to 8	2.6	16	11

Table 5.2: SOS 100: Gender/Age of Patients Receiving Supported Visits

Age Group	Male	Female	TOTAL
16-19yrs	1	1	**2**
20-29yrs	2	6	**8**
30-39yrs	9 (30%)	5	**14 (24%)**
40-49yrs	9 (30%)	12 (41%)	**21 (35%)**
50-59yrs	7	2	**9**
60-69yrs	0	0	**0**
70-79yrs	1	2	**3**
80-89yrs	1	1	**2**
TOTAL	**30**	**29**	**59**

Table 5.3: SOS 100: No of Supported Visits by No of Cases by Key Services *

Service	**1 Supported Visit**		**2 Supported Visits**		**3+ Supported Visits**		**TOTAL**	
	No of cases	No of Supp Visits	No of cases	No of Supp Visits	No of cases	No of Supp Visits	No of cases	No of Supp Visits
Penumbra	10	10	2	4	0	0	**12**	**14**
DAMH (activities and the drop-in)	6	6	0	0	1	4	**7**	**10**
Making Money Work	5	5	1	2	0	0	**6**	**7**
Connect	2	2	3	6	0	0	**5**	**8**
Listening Service	3	3	2	4	0	0	**5**	**7**
Remploy	2	2	2	4	0	0	**4**	**6**
Fairbridge	2	2	2	4	0	0	**4**	**6**
Small Steps to Confidence	3	3	1	2	0	0	**4**	**5**
DHLI (activities)	1	1	3	6	0	0	**4**	**7**
Adapt	3	3	0	0	0	0	**3**	**3**
Positive Steps	2	2	1	2	0	0	**3**	**4**
Action on Depression	3	3	0	0	0	0	**3**	**3**
Voluntary Opportunities	3	3	0	0	0	0	**3**	**3**
Adult Learning	3	3	0	0	0	0	**3**	**3**

*There will be an element of double counting as a case can appear at more than one service therefore no column totals are given

Table 6.1: SOS 100: Total Goal Assessment (where goal outcome known)

No of Goals Set	Yes Met	No Unmet	Partially Met
272	195 (72%)	40 (15%)	37 (13%)

Table 6.2: SOS 100: Goal Assessment by Age Group and Gender

	Yes Met			No Unmet			Partially Met			TOTAL		
	F	**M**	**ToT**	**F**	**M**	**ToT**	**F**	**M**	**ToT**	**F**	**M**	**ToT**
<20yrs	1	0	1	0	1	1	0	0	0	1	1	**2**
20-29yrs	3	2	5	2	0	2	0	1	1	5	3	**8**
30-39yrs	4	3	7	2	5	7	5	3	8 (33%)	11	11	**22**
40-49yrs	7	3	10 (23%)	9 (53%)	5	14 (45%)	4	4	8 (33%)	20	12	**32**
50-59yrs	5	3	8	3	1	4	1	4	5	9	8	**17**
60-69yrs	4	0	4	1	2	3	1	0	1	6	2	**8**
70-79yrs	4	1	5	0	0	0	0	0	0	4	1	**5**
80-89yrs	3	1	4	0	0	0	0	1	1	3	2	**5**
TOTAL	**31**	**13**	**44**	**17**	**14**	**31**	**11**	**13**	**24**	**59**	**40**	**99**

Table 6.3: SOS 100: Goals Unmet: Reasons Why and No of Services/Activities Not Accessed

Reason	No of Services/Activities
Did not meet Service Requirements	2 (Home Scotland; Cruise Counselling)
Deteriorating Mental Health (Motivation; Anxiety, Anger Issues)	7
Deteriorating Mental and Physical Health	1
Would Not Accept Help	2
Kept Putting Off Going	1
Patient Cancelled/Decided Not to Go	3
Patient Didn't Go/Turn Up	14 (one patient= 4 services involved)
No Suitable Service/Didn't Get What Wanted at the Service	2 (Post Traumatic Stress Peer Group; Insight Counselling)
GP Ref to Another Service	1
Initial Interaction with Service Off-Putting	2 (Cruise Counselling; Working Towards Health)
Other Priorities in Life at the Time	3 (Grandchildren)
Overwhelmed by Problems in Life	5
Leaving the Country	1
Service/Course was cancelled/folded	3 (Small Steps to Confidence Course)
Substance Misuse Issues	2
Have to Pay	1 (Penumbra)

Table 6.4: SOS 100: The Degree of Goal Achievement within Cases (N=95)*

100% Met	90% Met	75% Met	66% Met	50% Met	33% Met	0% Met
43 (45%)	3	15 (16%)	17 (18%)	9	1	7

* 5 cases where missing goal outcomes

Table 7.1. SOS 100: No of Cases by Goal Thematic

Goal Theme	No of Cases (N=99)
Mental Health	46 (46%)
Activities	26
Finance	24
Health	22
Social Isolation	18
Work Issues	9
Skills/Learning	8
Housing	6
Relationships	6
Confidence/Self Esteem	6
Substance Misuse	5
Literacy	5
Family Issues	5
Other Themes	4

Table 7.2: SOS 100: No in Each Age Group by Selected Goal Themes

	Finance	Health	Mental Health	Social Isolation
<20yrs	0	0	0	1
20-29yrs	4	5	6	4
30-39yrs	9 (26%)	6 (24%)	14 (25%)	2
40-49yrs	9 (26%)	8 (32%)	18 (32%)	6 (28%)
50-59yrs	3	3	8	2
60-69yrs	4	2	3	3
70-79yrs	3	1	2	2
80-89yrs	2	0	5	1
TOTAL	**34**	**25**	**56**	**21**

Table 7.3: SOS 100: Goal Thematic and Goal Assessment

Theme	Yes	No	Partial	TOTAL
Mental Health	34 (72%)	8	5	**47**
Activities	27 (76%)	6	1	**34**
Social Isolation	17 (63%)	6	4	**27**
Finance (Benefits)	21 (81%)	0	5	**26**
Finance (Other)	9	0	1	**10**
(ALL FINANCE)	31 (86%)	0	6	**36**
Health	14 (50%)	3	11	**28**
Work	11 (79%)	2	1	**14**
Confidence/Self Esteem	6 (46%)	4	3	**13**
Bereavement	2	3	0	**5**
Housing (Other)	18 (78%)	3	2	**23**
Housing (Homeless)	4	0	0	**4**
(ALL HOUSING)	22 (81%)	3	2	**27**
Carer	3	0	0	**3**
Family Issues/Relats	5	0	3	**8**
Skills/Learning	7	1	0	**8**
Literacy	5	2	0	**7**
Voluntary	4	1	1	**6**
Other Themes	8	1	0	**9**
TOTAL	**195**	**40**	**37**	**272**

Table 7.4: SOS 100: Goal 1 by Goal Thematic and Goal Assessment

Theme	Yes	No	Partial	TOTAL
Mental Health	14 (78%)	4	0	**18 (18%)**
Activities	15 (100%)	0	0	**15 ((15%)**
Social Isolation	10 (62%)	3	3	**16 (16%)**
Finance (Benefits)	7	0	2	**9**
Finance (Other)	3	0	0	**3**
(ALL FINANCE)	10 (83%)	0	2	**12**
Health	6	1	2	**9**
Work	5	1	0	**6**
Confidence/Self Esteem	3	0	1	**4**
Bereavement	0	3 (100%)	0	**3**
Housing (Other)	2	1		**3**
Housing (Homeless)	2	0	0	**2**
ALL HOUSING	4	1	0	**5**
Carer	2	0	0	**2**
Family Issues/Relats	2	0	0	**2**
Skills/Learning	1	0	0	**1**
Literacy	1	0	0	**1**
Voluntary	1	0	0	**1**
Other Themes	3	1	0	**4**
TOTAL	**77 (77%)**	**12**	**7**	**99**

Table 8: SOS 100: Summary Table: Goal Themes by No of Services Accessed and Cases

Goal Theme	No of Individual Services Accessed	No of Cases
Mental Health	17	46
Activities	15	26
Finance	9	24
Health	13	22
Social Isolation	9	18
Work Issues	5	9
Skills/Learning	7	8
Housing	6	6
Relationships	5	6
Confidence/Self Esteem	4	6
Substance Misuse	5	5
Literacy	2	5
Family Issues	4	5
Other Themes	3	4

Table 8.1: SOS 100: Individual Service Accessed by Goal Theme and No of Cases

Goal Theme: Health (includes self care)	Service Pathways	No of Cases
	Link Worker (self care)	3
	Health courses	3
	Pain Clinic	2
	Reiki	2
	Health Psychologist (via GP)	2
	Arthritis Group	2
	Chest, Heart and Stroke: Keep Fit Group	1
	Smoking Cessation	1
	Winning Weight	1
	Tai Chi	1
	Dundee Psychological Service	1
	Fybromyalgia Support Group	1
	Community Dentist	1
TOTAL	**13**	**22**

Goal Theme: Housing	Service Pathways	No of Cases
	Connect	1
	Sanctuary Housing	1
	Positive Steps	1
	Homeless Unit	1
	Home Scotland	1
	Medical Housing Officer	1
TOTAL	**6**	**6**

Goal Theme: Mental Health	Service Pathways	No of Cases
	Insight Counselling	9
	Listening Service	7
	Therapeutic Worker	6
	Penumbra	6
	LW (therapeutic)	3 (but it was inherent in their overall approach)
	GP	2
	Still Game (Dundee United Football Club)	2
	Dundee Association for Mental health (DAMH)	2
	Action on Depression	1
	Reiki	1
	Health Psychology	1
	Tayside Council on Alcohol (TCA) Art Therapy	1
	Arthritis Self Management Group	1
	University of the 3rd Age	1
	Adult Learning	1
	Mid-lin' Day Centre	1
	Art Angel	1
TOTAL	**17**	**46**

Goal Theme: Skills Learning Opportunities (includes learning practical household management)	**Service Pathway**	**No of Cases**
	Positive Steps	2
	Adult Learning	1
	Adult Guidance	1
	Volunteering (online info)	1
	Timebank	1
	Community Psychiatric Nursing Team (CPN)	1
	Ist Contact SW Team	1
TOTAL	**7**	**8**

Goal Theme: Literacy	**Service Pathway**	**No of Cases**
	Adult Literacy Team	4
	Dundee City Council Youth Literacy Team	1
TOTAL	**2**	**5**

Goal Theme: Activities	Service Pathway	No of Cases
	Active for Life	4
	Volunteering	4 (2 = Volun Gateway)
	Creative Writing Group	2
	Art Angel	2
	Walking Groups	2
	Dundee Association for Mental Health (DAMH)	2
	Crotchet Group	2
	Dundee City Council Youth Literacy Team	1
	Drama Therapy	1
	Dance Class	1
	Mid-lin' Day Centre	1
	Fairbridge	1
	YMCA Keep Fit	1
	Dundee Healthy Living Initiative (DHLI) Arts Group	1
	Tai Chi	1
TOTAL	**15**	**26**

Goal Theme: Finance	Service Pathways	No of Cases
	Making Money Work	9
	Connect	4
	Adapt	3
	Craigowl	1
	Welfare Rights	1
	North Law	1
	MSP (member of Scottish Parliament)	1
	Benefits Office	1
Fuel Poverty	Dundee Energy Efficiency Advice Project (DEEAP)	3
TOTAL	**9**	**24**

Goal Theme: Work Issues	Service Pathways	No of Cases
	Remploy	5
	MP	1
	Adult Guidance	1
	Dundee City Council Youth Literacy Team	1
	Link Worker	1
TOTAL	**5**	**9**

Goal Theme: Social Isolation	Service Pathways	No of Cases
	Dundee Association for Mental Health (DAMH)	4
	Fairbridge	3
	Dundee Healthy Living Initiative) DHLI	3
	Penumbra	2
	Positive Steps	2
	Adult Learning	1
	Discover Opportunities	1
	Volunteer Gateway	1
	Lattice	1
TOTAL	**9**	**18**

Goal Theme: Substance Misuse (includes alcohol	Service Pathways	No of Cases
	Tayside Council on Alcohol (TCA)	1
	Addaction	1
	Listening Service	1
	Tayside Alcohol Problem Service (TAPS)	1
	Eclipse	1
TOTAL	**5**	**5**

Goal Theme: Confidence Self Esteem	Service Pathway	No of Cases
	Steps to Confidence Course	3
	Discover Opportunities	1
	Link Worker (therapeutic)	1
	Brahamas	1
TOTAL	**4**	**6**

Goal Theme: Relationship Issues	Service Pathway	No of Cases
	Insight Counselling	1
	Offenders Family Helpline	1
	Link Worker (therapeutic)	1
Bereavement	Cruise Counselling	2
	Listening Service	1
TOTAL	**5**	**6**

Goal Theme: Family Issues	Service Pathways	No of Cases
	Dundee Early Intervention Team (DEIT)	2
	Discover Opportunities (D/O): Working Towards Health	1
	Dundee Healthy Living Initiative (DHLI): Cooking Group	1
	Leaflets on Family Activities	1
TOTAL	**4**	**5**

Goal Theme: Other Themes	Service Pathways	No of Cases
Carer	Carer's Centre	1
Traumatic Life Event	Child's Social Work Team	1
Abuse (previous)	WRASAC	1
Post Traumatic Stress	No Suitable Group	1
TOTAL	**3**	**4**

Table 9.1: SOS 100: No of Services/Activities Accessed

No of Services/Activities Accessed	No of Cases
1	7
2	30 (33%)
3	20 (22%)
4	13 (14%)
5	12 (13%)
6	5
7	3
8	1
10	1
TOTAL	**92**

Table 9.2: SOS 100: Commonly Used Services (5 or more cases referred and Service Accessed)

Insight Counselling	10
Making Money Work	9
Listening Service	8
Penumbra	8
DAMH	8
SOS Link Worker	7
SOS Therapeutic Worker	6
Positive Steps	5
Connect	5
Remploy	5

Table 10.1: SOS 100: Type of Role Undertaken by the Link Worker in Each Goal (N=280 Goals)

Type of Role	**No of Goals in which Role Undertaken**
Facilitate (referral/appointments)	204 (73%)
Negotiate	41 (15%)
Advocate	29 (10%)
Liaise	108 (39%)
Support	104 (37%)
Organise/Coordinate	67 (24%)
Information Giving and Research	121 (43%)
Advice	65 (23%)
Therapeutic Input	35 (12%)

Table 10.2: SOS 100: No of Link Worker Roles in Each Goal (N=280 Goals)

1 Role	**2 Roles**	**3 Roles**	**4 Roles**	**5 Roles**	**6 Roles**	**7 Roles**
52 (19%)	108 (38%)	52 (19%)	35 (12%)	23 (8%)	12 (4%)	1 (0.4%)

APPENDIX 2: GLOSSARY OF SELECTED SERVICES

ADDACTION: drug and alcohol support group for families, young people and adults

ADAPT: debt advice and money management service

CONNECT: focuses on the issues faced by people as a result of the benefits changes

CRAIGOWL: provides learning opportunities, training, qualifications, and support to people who want to improve their circumstances

DAMH (Dundee Association for Mental Health): umbrella organisation that provides a wide range of services (activities, support/advice, meeting place etc.) for people with mental health issues

DEEAP (Dundee Energy Efficiency Advice Project): provides advice and help on energy efficiency in the home

DEIT (Dundee Early Intervention Team): provides support to vulnerable children and families

DHLI (Dundee Healthy Living Initiative): provides opportunities and support for people to meet their health needs within their local community

ECLIPSE: a service for people striving to move into or maintain recovery from drug and alcohol problems

FAIRBRIDGE: provides individually tailored personal development plans for young people

LATTICE: local crafts group

MID-LIN DAY CENTRE: provides a wide range of activities for older people

PENUMBRA: promotes mental health and well-being

POSITIVE STEPS: promotes health and well-being and social lifestyles of vulnerable adults

REMPLOY: expands opportunities for disabled people in sustainable work both internally and externally

TAPS (Tayside Alcohol Problem Service): provides counselling and support to adults who feel they require advice or help with alcohol problems, and to their relatives

TCA (Tayside Council on Alcohol): provides advice and a range of services to adults, children and families with alcohol issues

TIME-BANK: a volunteering initiative that utilises and shares skills within local communities

WRASAC (Women's Rape and Sexual Abuse Centre): provides free and confidential support to women and girls aged 13+ who have been raped, sexually abused or sexually exploited

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