Strengthening adult safeguarding responses to homelessness and self-neglect:

Economic Analysis Report

Michela Tinelli[1], Jess Harris[2], Michelle Cornes[2,3], Stephen Martineau[2], Bruno Ornelas[4], Stan Burridge[5], Jill Manthorpe[2]

1 Care Policy Evaluation Centre (CPEC), the London School of Economics and Political Science (LSE)
2 NIHR Policy Research Unit in Health & Social Care Workforce (HSCWRU), King's College London
3 School of Health and Society, University of Salford
4 The Department for Levelling Up, Housing and Communities
5 Expert Focus Ltd

January 2024 | **CPEC Report**

Acknowledgements

This economic analysis is part of a national research study '**Opening the 'too difficult box': strengthening Adult Safeguarding responses to homelessness and self-neglect' (2019 – 2023)** led by the **NIHR Policy Research Unit in Health & Social Care Workforce** at **King's College London** working with the **Care Policy and Evaluation Centre** at the **London School of Economics**. The study was funded by the **NIHR School for Social Care Research** and has approval from the Health Research Authority (HRA) Social Care Research Ethics Committee: 20/IEC08/0040

Contact

Dr Michela Tinelli
M.Tinelli@lse.ac.uk

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1. Executive Summary

This report explores the economic dimensions of supporting extremely disadvantaged individuals experiencing Multiple Exclusion Homelessness (MEH), leveraging insights from three Safeguarding Adults Reviews (SARs) conducted across diverse English localities. Focused on the last year of life, these SARs offer a comprehensive examination of resource utilisation across services and sectors, laying the groundwork for an economic modelling study. Using economic modelling techniques, the research compares the service costs associated with the individual's 'unmet needs', which led to their death, against costs, and benefits, from the potential release or reinvestment of funding from meeting these needs more effectively. The analysis incorporates sensitivity analyses to test the resilience of the proposed model under various budgetary adjustments.

A central finding is the potential for cost savings across the local system by transitioning from urgent and emergency service contacts to planned, multidisciplinary support. The findings support timely and coordinated interventions, emphasizing the positive impact on both public resources and on individual wellbeing, for those experiencing MEH. They emphasise the important role of local voluntary and community sector organisations in providing essential support for this marginalised population. They underscore the importance of multidisciplinary collaborative working by diverse professionals across sectors, and early interventions to address the needs of this vulnerable population more effectively. It suggests the importance of integrated care systems and strong leadership to facilitate effective resource allocation and service models, that contribute to improved outcomes for individuals facing self-neglect and MEH.

To increase understanding of the long-term economic impact of interventions, particularly how sustained support could contribute to improved outcomes over an extended period, standardized and continuous data collection, as recommended by NHS England[1], are required for monitoring service provision and evaluating its impact on costs and outcomes.

What is Multiple Exclusion Homelessness (MEH)?

MEH is a term that describes the overlap between homelessness and other forms of deep social exclusion, such as experience of 'institutional care', substance use, and participation in 'street culture' activities:

'a distinctive and exceptionally vulnerable subgroup within the broader homeless population.' (Fitzpatrick et al., 2011)

A range of factors and risks contribute to people both *becoming* and *remaining* homeless, particularly 'street homeless'; these include adverse childhood experiences, trauma, mental illness, acquired brain injury, autistic spectrum conditions and learning difficulties. Past negative experiences of statutory services and of stigma and discrimination can contribute to mistrust and can deter people from seeking or accepting services or support.

[1] www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/

In conclusion, this report not only sheds light on the economic ramifications of different support scenarios but also supports a paradigm shift in how localities approach the complex challenges associated with self-neglect and homelessness. By emphasizing the economic benefits of proactive, multidisciplinary support, the study provides actionable insights for policymakers, commissioners, service providers, those in governance and quality assurance roles, and other stakeholders involved in shaping support to improve the wellbeing of this vulnerable population.

2. Introduction

Aim

The aim of this financial analysis was to build a robust economic approach to understand the full costs from public budgets of 'unmet needs' and unsafe care delivery for people experiencing homelessness and self-neglect, and to offer a comparative 'met needs' scenario, illustrating the potential for equivalent/reduced investments from public budgets to provide safer care and support to better meet people's needs, support them to improve their lives and to reduce levels of harms and deaths amongst people experiencing homelessness.

Background to the study

The estimated number of deaths among people experiencing homelessness increased by over 50% from 2013 to 2021, with the mean age at death 45.4 years for men and 43.2 years for women (ONS 2021). With such high risks associated with homelessness, how are local statutory services across England working to support and safeguard individuals?

The wider research study, of which this economic analysis is a part, focuses on Adult Safeguarding responses for people who are experiencing 'multiple exclusion homelessness' (MEH), a term used to capture overlapping experiences associated with profound social exclusion, including not just homelessness but also institutional care, substance use, and 'street culture' activities. One of the risks of MEH is 'self-neglect', which includes neglecting to care for one's health and wellbeing. Under the Care Act 2014 Guidance, self-neglect is a category of 'abuse and neglect' that triggers statutory safeguarding responsibilities. However, '…whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour'. Analysis of Safeguarding Adults Reviews (SARs), some of which feature the deaths of individuals experiencing homelessness, have indicated a lack, or failure, of safeguarding of people experiencing homelessness who self-neglect, which prompted this study to identify ways to improve outcomes for individuals.

The absence of economic evidence poses a significant challenge to understanding the cost-effectiveness and broader financial implications of services and support interventions. The study therefore aimed to establish an economic framework to explore the cross-sector public budget implications of better meeting needs and providing appropriate and timely support for those experiencing homelessness who self-neglect.

3. Economic Analysis Methods

Source of data and selection of case studies

Three study sites encompassing six English local authorities supported our analyses of SARs. A SAR is a multi-agency review process which seeks to determine what relevant agencies and individuals involved might have done differently that could have prevented harm or a death. The SARs were selected to report on cases of self-neglect and homelessness, and in each lead to the death of the individual. We met with practitioners from three different Communities of Practice (CoPs), developed in the study sites as part of the wider study, and discussed and agreed the selected SARs with CoP participants, who came from a range of roles, services, sectors and levels of seniority.

Building of the scenarios for analysis

The scenario presented within each SAR's chronology of service use and professional involvement was termed the 'unmet needs' scenario. We considered the unique health, care and support needs and service contact of each individual outlined in a SAR, and any gaps in details within the SAR chronology were filled, reflecting the opinions of experts. For each SAR, a 'met needs' scenario was then developed to describe what support and services could have been provided differently to address needs and prevent ultimately death. The priority was to provide effective and efficient support to better respond to individuals' needs, working within reasonable expectations of current service models and budgets. For each case we considered the critical challenges encountered by the individual because of their distinctive needs. We discussed with a range of practitioners, and with experts by experience, the opportunities to intervene and we benchmarked 'what good looks like' in order to modify the chronology of service use and professional involvement.

Economic modelling

For each scenario we mapped the type and number of contacts with services and staff time and seniority. We considered the economic implications for different budgets (i.e., statutory criminal justice, health (NHS), local authority, housing, mental health, and drug and alcohol services as well as voluntary and community sector provision). For each budget we further differentiated items of costs (for example, for local authorities we looked at adult social care, adult safeguarding, hospital social work, community outreach, community safety and enforcement, and housing) and costed them by applying unit costs for 2022. Possible gaps in the unit cost data (extracted mainly from published tariff and previous studies) were addressed by our different experts. Unit costs adopted for our calculations are detailed in appendix 1.

The timeline of the SAR chronologies varied from 11 to 24 months. For the one case (MS) where the timeline was 11 months, we applied temporal extrapolation methodology to project the economic evidence to a 12-month timeline. We assumed a fixed estimate of monthly costs derived from the 11-month timeline. For another case (Howard) we completed two sets of analysis: The main analysis looked at the last 24-months of his life, as analysed

within the SAR. The value of costs for the events occurred beyond 12 months was adjusted for the time they occurred using a health economic technique called discounting. According to standard practice we applied a rate of 3.5%. A second set of analysis looked only at the last 12 months of Howard's life, to enable comparability with the other two SAR cases.

In the main analysis we wanted to present the minimum amount of resources to be invested to realise the 'met' and 'unmet' needs scenarios'. But from our discussion with a range of experts, we knew that we needed to allow for flexibility in costs - unit costs are not fixed (for example, salaries may vary regionally) as well as variations in the staff time and seniority involved in service delivery across localities. A series of sensitivity analyses was conducted to test the robustness of our findings (Appendix 2).

For the 'met needs' scenarios, we felt we could not test for any cut in resources as our model had been developed to consider the minimum contacts with services and staff time needed to deliver safe care and meet the needs of the individuals. The 'unmet needs' scenarios, outlined in the SARs, described critical and unsafe situations where the individuals did not receive appropriate care, so we did not consider it feasible to consider further budget cuts.

Co-production with a range of experts

A series of meetings with the study's three Communities of Practices (CoPs) were organized to discuss the different cases, assumptions for the economic model, preliminary results once economic modelling was underway, and their interpretation. Similarly, the study's Advisory Group members, encompassing a range of expert stakeholders, supported the development of the analysis plan, the creation of the modelling, and the interpretation of the findings. In addition, nine experts with specific skills and knowledges (including a senior registered nurse, a safeguarding service manager, a housing consultant for a local authority, a health systems coordinator for substance misuse, a representative from a voluntary sector homeless organisation responsible for national practice development, a manager of a mental health team supporting people who are homeless, a safeguarding lead for policing, a social worker who is an approved mental health professional working in homelessness outreach, and a regional lead from probation services) acted as 'critical friends' and met one-to-one with the economic analysis team to test the scenarios and address technical queries on the model's assumptions (See Assumptions for the unmet and met need scenarios). A group of five 'experts by experience' with personal experience of MEH and self-neglect commented on the preliminary findings and provided important insights into what can work, or is unlikely to, in scenarios designed to meet the complex needs of people experiencing homelessness and self-neglect. The findings were also presented and discussed at a national webinar in 2023 with a wider stakeholder audience.

4. Results

Data were extracted from the three SARs summarised below. Both the practitioners and experts by experience confirmed that in all cases the priority was to provide care and support without infringing the human rights of the individual, and to act from a position of concern and empathy, not judgement. In addition, they emphasised that there is a duty of care for vulnerable people and for services to work collaboratively to respond to the complex, interacting needs that single-need and inflexible services may struggle to address. Our analysis presents the minimum resources needed to realise both 'met' and 'unmet' scenarios.

'Howard' (Isle of Wight Safeguarding Adult Board; 2018)

Howard was a tax adviser who loved cricket, sailing, and flying. His life spiralled out of control after he was jailed for fraud. He ended up on the streets, an alcoholic, regularly beaten and robbed by drug users. The main challenges described in the two-year chronology prior to his death, the 'unmet needs' scenario, were lack of collaboration between agencies, with health and social care agencies and emergency services not working together, and repeated missed opportunities to help Howard. At no point did the organisations attend a meeting together to agree a plan to address Howard's housing, health and social care needs.

The experts confirmed that the 'met needs' scenario would see Howard referred to adult safeguarding in the early months of year 1. A Section 42 Enquiry (Care Act 2014) would be triggered, and an initial multidisciplinary team (MDT) meeting would invite housing, health, adult social care, drug and alcohol, mental health and specialist voluntary sector agencies to collaborate and agree who will lead on defined responsibilities. Mental capacity assessments would be completed in hospital, relating to specific care and support decisions, and his needs would be identified and met through a Care Act 2014 needs assessment, plus though referral to Housing Options to discuss different housing and local authority allocations. Voluntary and community sector specialist organisations would support Howard to attend meetings and appointments, and to access welfare benefits and community support options. Domiciliary care would last for a substantial part of the chronology until Howard moves to a care home with nursing at the end of year two.

'Jonathan' (Northamptonshire Safeguarding Adult Board; 2020)

Jonathan was a white British male with a 'normal' life and was popular amongst his peers. When he reached early adulthood his relatives noticed changes to his behaviour; he started drinking to excess and experimenting with drugs. He ended up rough sleeping on the streets, an alcoholic, regularly beaten and robbed by drug users. He died in a hotel room, aged 46 on 31 December 2019.

The chronology of his last year of life was considered for analysis. Lack of collaboration between agencies was highlighted which did not allow for any joint interventions where appropriate. There was a clear failure to implement a meaningful and personalised plan of action and to assess his social care needs, so his needs were only viewed as a housing issue. The threshold criteria under section 42(1) of the Care Act 2014 were met which should have brought a safeguarding enquiry. The professionals' meetings lacked structure and meaningful action planning, and evidence of the risks should have activated Adult Risk Management (ARM).

In a 'met needs' scenario, in early January Jonathan would have been discharged from hospital; a Section 42 Enquiry would have been triggered, and an ARM would have been in place. The ARM would have provided a safe and effective framework for addressing risks through timely information-sharing and coordinated assessment and planning. Inter-agency communication and collaboration would have been in place. His needs would have been met through a Care Act 2014 needs assessment plus referral to Housing Options. Voluntary sector services would have helped him with housing and legal advice, setting up a bank account and accessing benefits and support. Outreach services would have been involved to accompany Jonathan to appointments, etc. Domiciliary care would have been arranged for the rest of the year.

'MS' (City and Hackney Safeguarding Adult Board; 2021)

MS was a Turkish (Kurdish) male, aged 63-years old with a history of homelessness, self-neglect and substance abuse. He ended up on the streets, misusing alcohol, regularly beaten and robbed by drug users. MS was found to have died of natural causes. Prior to his death, he had recently been evicted from a care home and, whilst he had been offered alternative accommodation, he refused this.

A lack of multi-agency working and coordination was identified, with no agency or professional taking the lead for MS's care. No multi-agency meeting took place prior to his eviction. Language may have been a barrier, but qualified interpreters were used on rare occasions. Assessment of MS's executive functioning had been omitted. Advocacy should also have been considered throughout the period.

In the 'met needs' scenario, appropriate support would have been in place early in the chronology, when MS was living in a hostel. A multi-agency meeting would take place prior to him leaving the hostel, using qualified interpreters. With a Care Act 2014 assessment and referral to Housing Options he would have received appropriate support. He would not have been evicted, a transition would have been managed, and he would have been placed in a studio flat. He would have received a mental health assessment by the Community Recovery Service, but there would be no need of community outreach. An allocated key worker would have visited once a week and he would have received care and support at home for the entire period via a personal budget for meals and a personal assistant. The local authority Street Outreach Team, including specialist Mental Health provision, would have linked MS to services. Advocacy services would have assisted MS to engage in assessments, decision-making about care planning and connecting with the community.

The more detailed chronology for each of the three cases and their 'unmet/met needs' scenarios is presented below, under 'Assumptions for the unmet and met need scenarios'.

The cost of unmet and met needs

The cost of 'unmet needs', the actual care and contact with services in the last year of life outlined in the three SAR chronologies, varied from £64,900 (Howard) to £84,300 (MS), whereas the annual cost to keep the individuals safe and to secure, outlined in the 'met needs' scenarios, varied from £40,300 (MS) to £89,400 (Howard). Details are provided in Tables 1 - 3, below.

From the economic analysis calculations, the proportion of resources invested varied according to the individual's story and distinctive needs (Figure 1). When considering the SAR chronology, for both Howard and Jonathan, most of the costs were the use of NHS general services (e.g., hospitalisations, ambulance calls and A&E visits (53% and 44% of costs respectively). MS, in contrast, mainly accessed NHS mental health services (42% of costs).

For the 'met needs' scenario, most of the funding needed to support Howard came from local authority social care and housing budgets (approximately 69%). This supported community-based services and enabled Howard to live at home, supported, until his health deteriorated further and he agreed to move to a care home with nursing. For Jonathan, 62% of the 'met needs' funding covered integrated provision of community care from the NHS and local authority. Multidisciplinary teams were the preferred mechanism for coordinating health and social care services to meet Jonathan's needs. For MS, about 60% of the 'met needs' budget came from the local authority (mainly domiciliary care and community support).

In all three 'met needs' scenarios, part of the budget (approximately £3000 per case) was allocated for support from the voluntary and community sector, as they helped all cases when navigating their options, making and maintaining contact with services, and via various community support initiatives. According to the 'met needs' model proposed by the experts, voluntary organisations providing support would join monthly discussions of the cases with the statutory multi-disciplinary team and provide updates and advice. Our experts suggested that the preferred model would be a multidisciplinary team, providing specialised outreach, with integrated social care and health, including mental health and drug and alcohol expertise. It would provide coordinated person-centred care and support until the case was resolved.

For Howard, the economic modelling suggests an investment of an additional £24,000 of public money was needed to secure appropriate support and better outcomes compared with his SAR chronology (Table 2). For Jonathan and MS, the economic modelling suggests that appropriate care and support would have secured better outcomes and have generated cost savings across the local system (annual savings of £30,000 and £40,000 respectively). This is mainly due to the model assuming fewer contacts with criminal justice and health services (Jonathan) and with mental health services (MS). Sensitivity analyses tested the robustness of the model (for full details see appendix 2).

5. Conclusion

The focus on the economics of responding to self-neglect is fundamental to understanding its broader impact on both individuals and society, particularly in the context of socially excluded and vulnerable populations such as those experiencing homelessness. Self-neglect has profound implications for mental and physical and wellbeing, mortality rates, and health and social care use, so the economic dimension is an essential layer of understanding for policymaking, service design, commissioning, delivery and evaluation across organisations and sectors.

Measuring the economic impact of self-neglect provides an evidence base for assessing the cost-effectiveness of interventions. By evaluating the economic implications across a local system of service approaches leaving unmet needs, leading to harm or death, and comparing them with the costs, potential savings and benefits of effective support, informed decisions can be made about resource allocation and service design. The economic analysis presented here highlights the value of timely and coordinated multi-disciplinary interventions, potentially freeing up public resources for more effective reinvestment, reducing the pressures on emergency and criminal justice services, and yielding better outcomes for individuals.

This study presents a pioneering approach to developing economic data from analysis of SARs cases, and offers a model and messages that warrant further exploration. The core finding is that in two out of three cases analysed, the shift from the use of urgent and emergency services to planned multidisciplinary support would have resulted in potential cost savings across the time period analysed. The analysis findings also underscores the role of the voluntary and community sector in providing essential support to a distinctly marginalised community, and emphasises the need for a multidisciplinary cross-sectoral approach with ongoing collaboration among professionals.

However, a significant challenge to conducting a rigorous economic analysis is the availability or lack of comprehensive cost and outcome data. The absence of real-life case information, and insights into the longer-term economic impacts of support, limit the depth of analysis. To address this, our study employed a case story approach, drawing on SARs from three disparate English localities. While this innovative approach provides valuable insights, we would emphasise the need for standardised and continuous data collection to enhance the scale and robustness of future economic analyses. This analysis did not allow for cost-effectiveness modelling, a pathway that could offer a more nuanced understanding of the efficiency of different support scenarios; to conduct this, additional data on the quality of outcomes would be essential.

The strengths of our approach include the collaboration with a broad range of experts to address data gaps, contributing to the creation of the support scenarios analysed here. There are limitations from relying on individual expert opinions and the potential impacts on the robustness of proposed scenarios; we addressed this by testing the scenarios with our Study Advisory Group, and with practitioners in an online webinar. Differences in expert opinions could potentially impact the robustness and objectivity of the proposed scenarios, though sensitivity analyses were employed to test their validity. The focus on the last year

of life narrows the exploration of preventive measures and early interventions that might have taken place to reduce or prevent escalating levels of need, and assumptions about the applicability across diverse settings raises questions about the universality of the model developed. A broader temporal perspective might offer a more holistic understanding of the economic implications associated with self-neglect and homelessness.

Moving forward, it may be helpful to build on this model and carry out economic analyses as a component of SARs and other case reviews. This would depend on the establishment of a systematic approach to data collection, analysis, and reporting. Standardised and continuous data collection, as recommended by NHS England[2], is imperative for monitoring service provision and evaluating its impact on costs and on outcomes for individuals. This, coupled with a careful consideration of participants' expectations about service models, would enhance the applicability of the economic modelling and so could improve decision making.

Finally, the analysis's potential to drive change depends on how well it resonates with stakeholders. If these economic implications are effectively integrated into policymaking, they can serve as a catalyst for systemic improvements. The study not only highlights the potential economic benefits of coordinated interventions but also supports the need for integrated care systems, leadership, and more effective resource allocation to achieve better outcomes for individuals facing homelessness and self-neglect.

[2] www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/
www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/

Table 1: Fundings to be invested to keep Howard safe and meet his needs (Isle of Wight Safeguarding Adult Board; 2018)

	Costs for unmet needs (£, 2022)	Costs for met needs (£, 2022)	Difference in costs (£, 2022)	Colour coding
Model 1: When considering the last 24 months of SAR				
Criminal justice	2,427	539	-1,887	Cash release
Drug and Alcohol Service	4,019	4,754	734	Similar budget
Health [elective]	424	33,028	32,604	More funding to be invested
Health [non-elective]	37,527	1.586	-35,941	Cash release
Housing [specialist support, statutory or voluntary]	28,943	15,157	-13,786	Cash release
Adult Social Services	6,176	52,493	46,317	More funding to be invested
Mental Health Services	2,168	163	-2,004	Cash release
Voluntary sector*	1,339	7,321	5,982	More funding to be invested
Total for 24 months	**83,023**	**115,040**	**32,018**	**More funding to be invested**
Model 2: When considering the last 12 month of SAR				
Criminal justice	1,050	419	-632	Similar budget
Drug and Alcohol Service	2,376	4,920	2,544	More funding to be invested
Health [elective]	357	13,899	13,542	More funding to be invested
Health [non-elective]	34,143	4,786	-29,357	Cash release
Housing [specialist support, statutory or voluntary]	15,964	33,876	17,912	More funding to be invested
Adult Social Services	8,605	27,805	19,200	More funding to be invested
Mental Health Services	1,733	175	-1,558	Cash release
Voluntary sector*	699	3,504	2,805	More funding to be invested
Total for the last 12 months	**64,926**	**89,382**	**24,456**	**More funding to be invested**

* Non statutory support work, assessment and community support

Table 2: Cost saving when keeping Jonathan safe and meeting his needs (12 months) (Northamptonshire Safeguarding Adult Board; 2020)

	Costs for unmet needs (£, 2022) ^	Costs for met needs (£, 2022) ^	Difference in costs (£, 2022) ^	Colour coding
Costs:				
Criminal justice	17,155	6,283	- 10,871	Cash release
Health [elective]	79	13,735	13,655	More funding to be invested
Health [non-elective]	36,651	4,477	- 32,174	Cash release
Housing [specialist support, statutory or voluntary]	16,686	9,677	- 7,009	Cash release
Adult Social Services	10,718	9,353	- 1,365	Cash release
Mental Health Services	715	175	- 540	Similar budget
Voluntary sector*	979	4,290	3,311	More funding to be invested
Total for 12 months	**82,982**	**47,989**	**- 34,993**	**Cash release**

^ 12 months' period. * Non statutory support work, assessment and community support

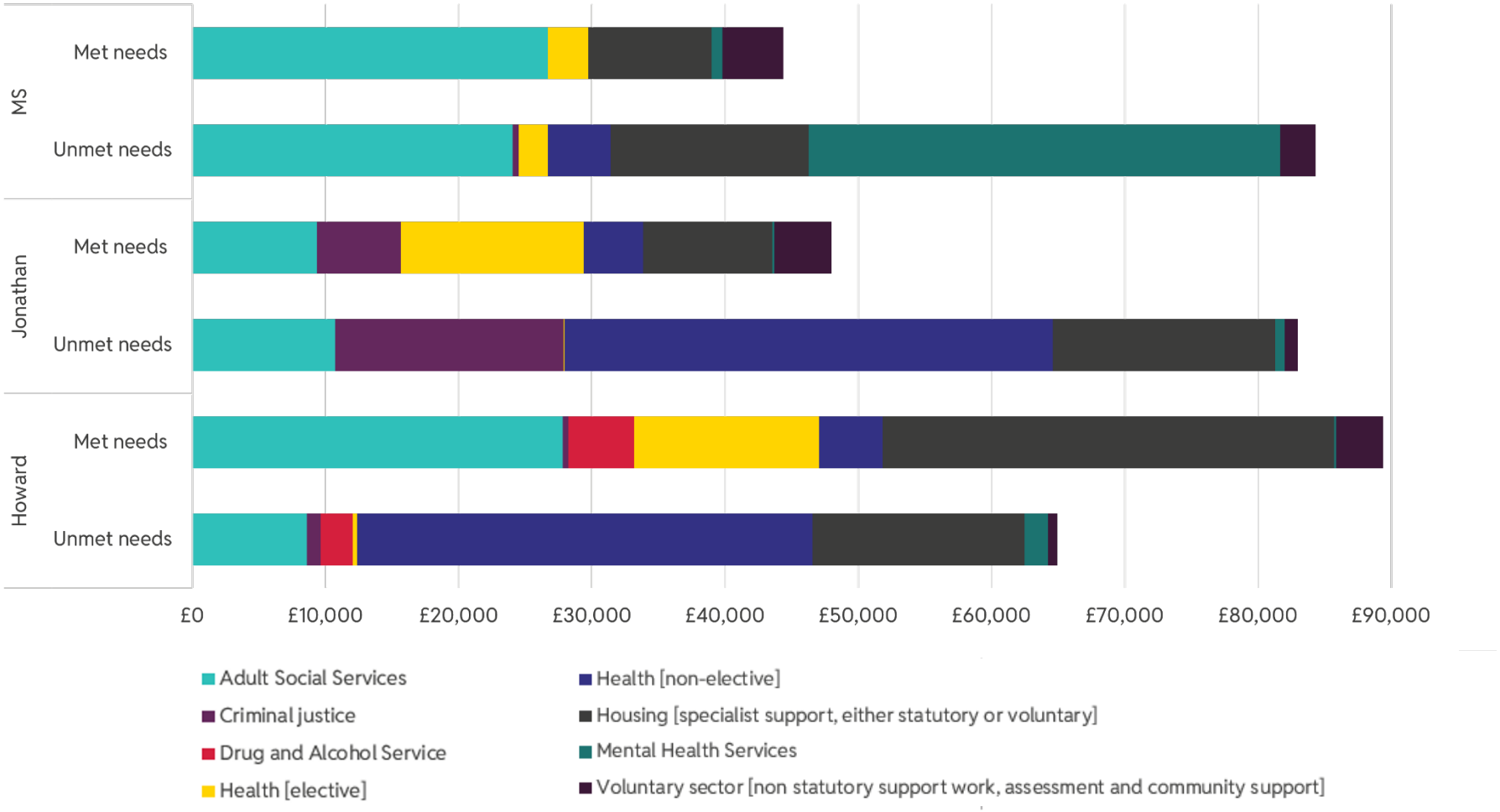
Table 3: Fundings to be invested to keep MS safe and meet his needs (12 months) (City and Hackney Safeguarding Adult Board; 2021)

	Costs for unmet needs (£, 2022) ^	Costs for met needs (£, 2022) ^	Difference in costs (£, 2022) ^	Colour coding
Costs:				
Criminal justice	458	-	-458	Similar budget
Health [elective]	2,159	3,064	905	More funding to be invested
Health [non-elective]	4,715	0	-4,715	Cash release
Housing [specialist support, statutory or voluntary]	14,881	9,255	-5,626	Cash release
Adult Social Services	24,049	26,665	2,616	More funding to be invested
Mental Health Services	35,406	803	-34,604	Cash release
Voluntary sector*	2,668	4,585	1,917	More funding to be invested
Total for 12 months	**84,336**	**44,371**	**-39,965**	**Cash release**

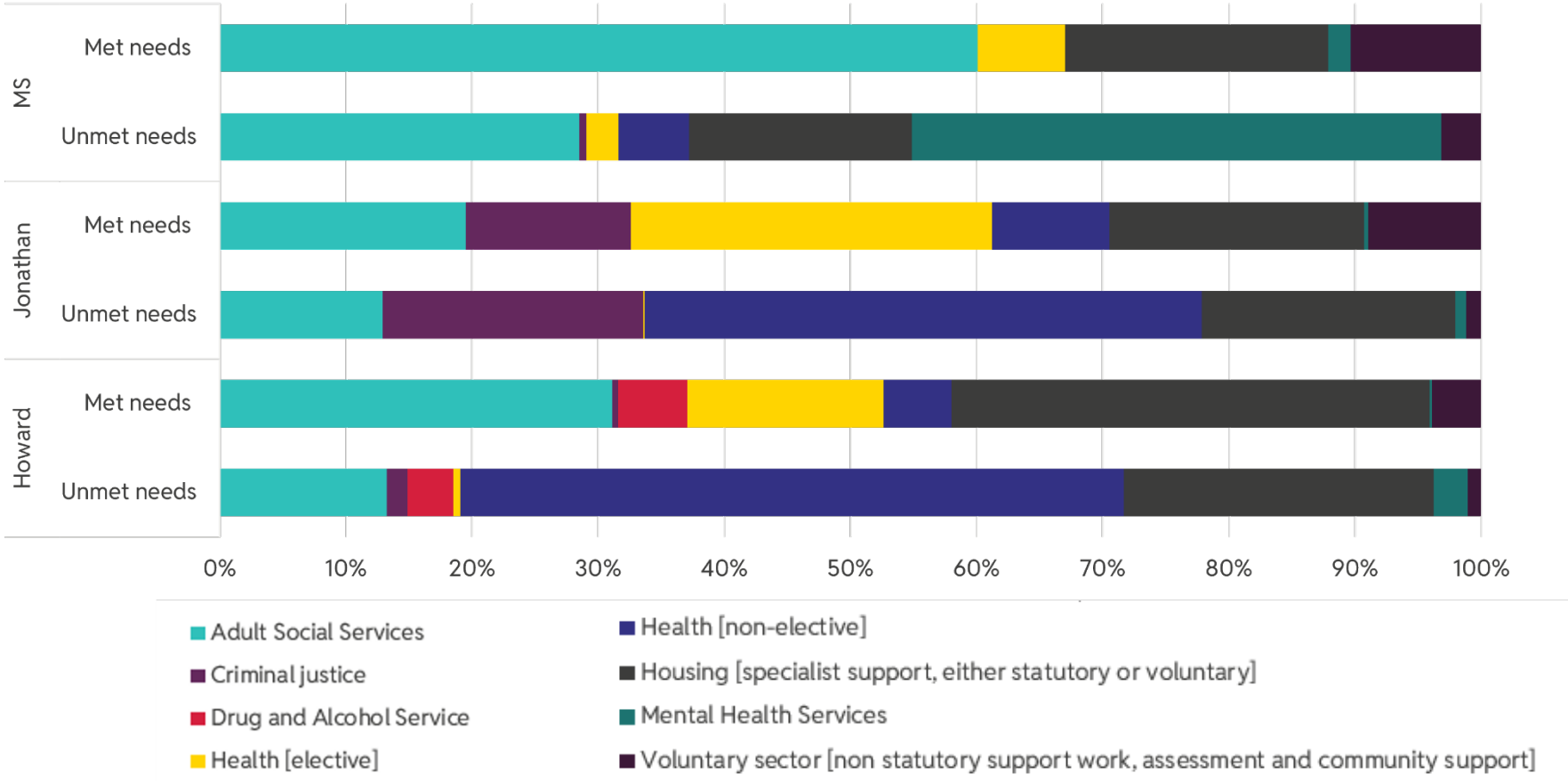
^ 12 months' period. * Non statutory support work, assessment and community support

Figure 1: Resources to be invested for the different cases (met needs compared with unmet needs; considering the last 12 months for all three case stories)

A) Amount (£) of resources to be invested



B) Proportion (%) of resources to be invested



Appendix 1: Assumptions for the unmet and met need scenarios

Table A1: 'Howard' Isle of Wight (Isle of Wight Safeguarding Adult Board; 2018)

	Unmet needs' chronology (Adapted from the SAR chronology with support from the experts) [24 months]	Met needs' chronology (Adapted from the SAR chronology with support from the experts) [24 months]
Criminal justice	• 23 interactions, including referrals and paperwork with other agencies. Overall, 7 hours attending officer time accounting for everything (visiting on site, liaison, meetings, and paperwork) per contact. • Paid for his return to Isle of Wight and for two nights in a hotel on arrival.	• We assumed 4 calls. Per event we assumed: 1.5 hours for one attending officer. Plus, time in liaison with multiagency: Three hours per case (for two staff, sergeant plus civilian).
Drug and Alcohol Service	• We assumed a total of 6-7 months contact with the services (on and off, including missed appointments and delays, communication with H and other agencies). Direct time: Psychosocial intervention, unqualified practitioner: 1 hour a week. Community contacts: 20 min, 3 times each week. Forensic psychologist @ £120 per month. Indirect time for each hour we considered an additional 1/10 of time for paperwork, calls etc.	• 12 weeks: Direct time: Community contacts: 1 hour, 3 times per week (@£20-25 per hour). Psychosocial intervention: Twice a week (£35 each psychosocial unqualified staff). Forensic psychologist: 1 hour per week (£60 per hour). Antipsychotic medications and methadone (included in psychologist fees). Psychosocial intervention should include personalisation, to engage effectively, e.g. clothes, etc (not included). Indirect time: for each hour direct time, accounted for 1 additional hour indirect time for multiagency meeting, calls, referrals etc.
Health [elective or non-elective treatments]	• GP: we assumed a total of 12 contacts and visits across the period. • Urgent Treatment Centre: we assumed about 6 visits. • Assumed at least 12 visits at the A&E, 10 hospitalisations, one outpatient visit, 10 ambulance calls.	• GP: we assumed a total of 8 contacts and visits across the period. • Community nurse wound services: 14 visits with the wound nurse. • 1 NHS continuing healthcare assessment (20 hours staff time, average band 6 and 7). • 1 visit Urgent Treatment Centre, one visit A&E, one elective hospitalisation, one emergency hospitalisation, 8 outpatient visits, 1 ambulance call. • 2 Intermediate care step-down (residential) stays (14 days each) 2 Intermediate care step-down (community) stays (14 days each)
Housing [specialist support,	• We assumed contacts with housing across the 2 years. ~10 hours per week. We assume 5 hours per week per case for case officer (£15 per hour) plus 5 hours on management time (£46 per hour).	• One Housing Options Assessment (4 hours to include preparation, assessment and post assessment, £15 per hour * two people required). • Personal housing plan included 2 hours per week for 84 weeks = period H stayed in accommodation. 3-4 people staff time: Housing officer

statutory or voluntary]	• We assumed about 7 months in temporary accommodation (e.g., homeless bus shelter, Crawley Open House).	(applying legal framework), rough sleeper worker (outreach and in-reach), and coordinator officer. • H lived 84 weeks in social tenancy.
Adult social care/safeguarding	• Referral to adult safeguarding, average £620, about 14 hours, Including: Social worker practitioner plus senior practitioner and team managers.	• Section 42 Enquiry and protection plan was completed. It lasted about 6 weeks; we assumed 2 days a week staff time • Cost per safeguarding referral of £620 average 14 hours.
Adult social care	• 6 months of contacts overall; 4 hours per week: Based on time spent on a 'high' intensity case of an adult who self-neglects over four-week period (social worker 3 hours) plus one additional hour for indirect time. • One independent medical advisor visit • One Care Act 2014 needs assessment	• None
Adult social care	• about 10 contacts with a social work practitioner at the hospital.	• None
Adult social care	• none	• Domiciliary Care (14 hours per week) per 84 weeks • Meals on Wheels per 84 weeks • One key safe • 12 weeks nursing home
Mental Health Services (NHS)	• Hospital mental health liaison services: 5 contacts. 1.5 hours per person with recovery worker; plus 1.5 hour with band 4; plus 1.5-hour forensic psychologist; plus 1.5 hours psychiatrist including antipsychotic medications and methadone. This includes direct and indirect time. • Community mental health services: limited contact (2 times per year). • One community mental health assessment in last year.	• One hospital mental health assessment. • No need of community mental health services
Voluntary sector [assessment and community support]	• No assessment/support plan. • Staff contact about 2 hours contact per month for the whole period	• Assessment and support plan: 2 half-day sessions (£180 per session). One half day session senior practitioner, plus half day session for ongoing case discussion. Outreach reports case to voluntary organisation who do assessment; voluntary organisation joins monthly case discussion with outreach team and provides advice. Staff contact: 3 hours per week.

Table A2: 'Jonathan' Northamptonshire (Northamptonshire Safeguarding Adult Board; 2020)

	Unmet needs' chronology (Adapted from the SAR chronology with support from the experts) [12 months]	Met needs' chronology (Adapted from the SAR chronology with support from the experts) [12 months]
Criminal justice	• 9 interactions with J, including referrals and paperwork with other agencies. Overall, 7 hours for attending officer (30K per year, £15 per hour) time accounting for everything (visiting on site, liaison, meetings and paperwork) per contact. • 3 arrests, 68 nights in custody, 3 criminal damage offences, two Magistrate court appearances, one Magistrate court application. • Community probation services for 12 weeks: officers time per visit include half hour with individual plus 45 minutes indirect time per week. Supervisory time include person safety leads, 30 minutes per 6 people: One band 8 manager £45k, Operational service officer £30K , one senior probation officer £40K, one band 4 probation officer 30K, one band 3 probation service officer £25K, one prison employed psychologist trainee £35k. • Food parcel for a week.	• We assumed one interaction with the police, one arrest, 30 days in custody, one Magistrate Court appearance. • We assumed probation services for 12 weeks after release from prison. Community probation officers time per visit would be half an hour with the individual plus 45 minutes indirect time per week. Plus multidisciplinary review (2 hours per 6 people for the 12 weeks - £35k average salary including accommodation officer, community probation officer, and key workers.
Drug and Alcohol Service	• N/A	• N/A
Health [elective or non-elective treatments]	• two visits with the GP, 21 A&E visits, 9 unplanned hospitalisations, Travelling to housing office/hotel, 9 ambulance call and one outpatient visit.	• 4 visits with GP, 10 visits with community nurse wound services, one hospitalisation, 14 days in intermediate care step-down (residential) care plus 14 days in intermediate care step-down (community) care. • We assumed 8 outpatient visits and one ambulance call.
Housing [specialist support, statutory or voluntary]	• ~10 hours per week for the year. 5 hours per week per case for case officer (£15 per hour) plus 5 hours on management time (£46 per hour). • Travelling fares for J to attend probation appointment/accommodation meeting. • Needs assessment	• One needs assessment • One Personal Housing Plan and review • Stay in own tenancy (social accommodation)

	• Food and bedding • 6 weeks in total in temporary accommodation	
Adult social care/safeguarding	• Referral to adult safeguarding	• Section 42 Enquiry and protection plan completed. It lasted 6 weeks and we assumed 2 days a week staff time • Referral to adult safeguarding, average £620, about 14 hours, Including: Social worker practitioner plus senior practitioner and team managers.
Adult social care	• We assumed contacts with ASC for the entire time; 4 hours per week • One care act assessment • Community support from August 15 on/off (1 hour community support worker per week for 18 weeks)	• One assessment • Two multidisciplinary meetings; discussion with social care emergency duty team (EDT) • Community support worker time would be 3 hours a week
Adult social care	• Two contacts with the hospital complex discharge team	• None
Adult social care	• None	• 3 hours per week
Mental Health Services (NHS)	• One Hospital Mental health assessment • Four contacts with the Hospital mental health liaison services	• One Hospital Mental health assessment
Voluntary sector [non statutory support work, assessment and community support]	• Provision of incontinence pads, hot meal, shower, etc (Daylight Centre Fellowship) • Assessment and support plan: Half day session from outreach team, senior practitioner (£180 for session). If someone not engaging would be multiple visits - several days senior practitioner input across several months. Average: Initial assessment – 2 to 6 half day sessions. (Based on Enabling Assessment Service, London) • Contact with a voluntary sector worker for ~ 2 hours per month.	• Assessment and support plan: see Howard case for details. • Contact with a voluntary sector worker for ~ entire period, 3 hours per week.

Table A3: 'MS' City and Hackney (City and Hackney Safeguarding Adult Board; 2021)

	Unmet needs' chronology (Adapted from the SAR chronology with support from the experts) [original 11 months' timeline]	Met needs' chronology (Adapted from the SAR chronology with support from the experts) [original 11 months' timeline]
Criminal justice	• We assumed 4 calls out, see Howard case for details	• Zero contacts with police
Drug and Alcohol Service	• N/A	• N/A
Health [elective or non-elective treatments]	• We assumed 3 GP contacts, one NHS continuing healthcare assessment, one visit to A&E, 3 ambulance calls and one long stay in hospital and. • We assumed one outpatient visit, 6 visits with the Tissue Viability Nurse, one speech and language assessment, one visit with language therapist, one mental capacity assessment, one cognitive assessment, one vascular assessment and possible claudication.	• We assumed 2 GP visits, one NHS continuing healthcare assessment. • 6 outpatient visits, 10 visits with the Tissue Viability Nurse, one speech and language assessment, one visit with language therapist, one mental capacity assessment, one cognitive assessment, one vascular assessment and possible claudication.
Housing [specialist support, either statutory or voluntary]	• We assumed he was in contact with housing services for the 11 months. ~10 hours per week. We assume 5 hours per week per case for case officer plus 5 hours on management time. • We budgeted for 5 nights in temporary accommodation.	• He had a Personal Housing Plan and review. • We assumed he lived in social accommodation (own tenancy) for the entire time.
Adult social care	• We considered cost per referral to safeguarding, about 14 hours of social worker practitioner time plus senior practitioner and team managers.	• Cost per referral to safeguarding, about 14 hours social worker time plus senior practitioner and team managers. • Section 42 Enquiry with referral to Care Management and protection plan
Adult social care	• 4 hours per week for 11 months. 3 hours social worker time plus one additional hour for indirect time. • MS spent 145 days in Care Home Dementia Unit • 3 visits from community safety and enforcement and one Community Protection Notice. • One care act assessment	• We budgeted for 2 multiagency meetings and time for a community outreach officer 3 hours per week.

Adult social care	● We budgeted for hospital social work practitioner (~ 3 hours hour staff time)	● None
Adult social care	● None	● Care package (for the 11 months) included: Domiciliary Care (14 hours per week), Meals on Wheels, one key safe, and a community support worker, one hour per week.
Mental Health Services	● One Mental health assessment on street by Community Hackney Recovery Service and one Deprivation of Liberty assessment completed. ● considered 6 contacts with community mental health team services, (Community Mental Health Team Service) (face to face and non-face to face).	● We assumed one Mental health assessment by the Community Recovery Service, but there would be no need of community outreach support.
Voluntary sector [assessment and community support]	● We assumed contact with voluntary sector (e.g., voluntary sector worker including welfare checks and referrals), 8 months 2 hours a month; last three months 5 hours a week.	● Assessment and support plan delivered with 2 half-day session (£180 for session), see Howard case for details. ● MS received support from voluntary sector staff (3 hours per week) to join events in the local community, etc.

Appendix 2: Unit Costs

Budget	Scenario	Item	Assumptions base case	Unit costs (actualised 2021)	Source
Criminal justice	unmet needs	Police: paid for his return to the Isle of Wight and for two nights in a hotel on arrival	travel £30 (https://www.rome2rio.com/) plus two nights in hotel @ £40 per night (premierinn.com)	£ 110	Expert opinion
	unmet needs	Police: contact/call out (cost of dealing with incident)	Overall, 7 hours for attending officer (30K per year, £15 per hour) time accounting for everything (visiting on site, liaison, meetings, and administration).	£ 105	Expert opinion
	met needs	Police: contact/call out (cost of dealing with incident)	Call out: Attending officer time in total 1.5 hours with paperwork (30K per year, £15 per hour). Plus, time in liaison with multiagency bodies. Three hours per case (£24 hour sergeant plus £15 per hour civilian).	£ 140	Expert opinion
	unmet needs	Police: arrests		£ 761	The Greater Manchester Combined Authority Unit Cost Database 2019
	unmet needs	Police: nights in custody	£38,974 per annum / 365	£ 109	GMCA Unit Cost Database 2019
	unmet needs	Police: Criminal damage offence	Crime - average cost per incident of crime, across all types of crime	£ 1,036	GMCA Unit Cost Database 2019
	unmet needs	Magistrate court appearance		£ 1,043	Harries (1999): inflated to 2020 prices using HCHS
	unmet needs	Magistrate court application	116.60 to 1,577.53 (2020 figures); average: £847	£ 847	CPS. Application for costs against convicted defendants - Scales of Cost (2009)

		Probation services: before the release	Community probation officer: 2-4 contacts with the family to check the address. If address is not suitable, look for another address. The same process (e.g., 3 visits, one hour each, £ 20 per hour) can be repeated 3 or 4 times. If not successful, case is referred to Bail, Accommodation and Support Service (BASS). BASS provide accommodation to offenders from courts, and from custody.	N/A We consider only costs after the release.	Expert opinion
	unmet needs	Probation services: after the release (12 weeks duration)	Community probation officer's time per visit: Half an hour with the individual plus 45 minutes indirect time per week. Supervisory time to be costed: Person safety leads - 30 minutes per 6 people for the 12 weeks, including: 1. One band 8 manager £45k 2. Operational service officer £30K 3. senior probation officer £40K 4. band 4 probation officer 30K 5. band 3 probation service officer £25K 6. psychologist trainee employed by prison £35k	£ 357	Expert opinion
	met needs	Probation services: after the release (12 weeks duration)	Community probation officers time per visit: Half an hour with the individual plus 45 minutes indirect time per week. Multidisciplinary review - 2 hours per 6 people for the 12 weeks - £35k average salary including accommodation officer, community probation officer, and key workers.	£ 1,116	Expert opinion
	unmet needs	Probation services: food parcel	food bank's lowest-priced, one-week food list	£ 19	Furey et al (2018) The Differential Cost of an Emergency Food Parcel and a Consensually Acceptable Basket of Healthy Food
Drug and Alcohol Service	unmet needs	Drug and alcohol services (adults): Costs per person per week	Direct time: Psychosocial intervention, unqualified practitioner: 1 hour a week (£30). Community contacts: 20 min, 3 times each week (@£25 per hour). Forensic	£ 149	Expert opinion

			psychologist, @ £120 per month. Indirect time: add 1/10 of the time.		
	met needs	Drug and alcohol services (adults): Costs per person per week	Direct time: Community contacts: 1 hour, 3 times each week (@£20-25 per hour). Psychosocial intervention: 2 times a week (£35 each for psychosocial unqualified member staff). Forensic psychologist: 1 hour per week for (£60 per hour). Plus, antipsychotic medications and methadone (already included in the fees for the Forensic psychologist). Indirect time: for each hour of direct time, we account for one additional hour indirect time for multiagency meeting phoning, person referrals etc	£ 410	Expert opinion
Health	met/unmet needs	GP: time for visits	9.22 minutes per consultation		Curtis et al (2020)
	met/unmet needs	GP: additional time for referrals, arranging admissions, external meetings etc	Ratio face-to-face time (in consultation with the patient): indirect time (deskwork for referral letters, arranging admissions, meetings and preparation time) is 1:0.7		Curtis et al (2020)
	met/unmet needs	GP: costs per minute	Costs include wage/salary; salary oncosts; overheads; capital costs (see Curtis et al 2020)	£ 4	Curtis et al (2020)
	met needs	Tissue viability nurse (referrals, contacts) Tissue Viability Nurse Band 7: per contact	we assume one hour time per contact	£58	Curtis et al (2020)
	met needs	NHS continuing healthcare assessments: staff time	amount of time taken to conduct a full assessment i.e. 20 hours staff time, average band 6 and band 7 (£53)	£ 1,060	expert opinion
	met/unmet needs	Urgent Treatment Centre (outpatient clinic): cost per visit		£ 137	Curtis et al (2020); (Weighted average of all outpatient attendances)
	met/unmet needs	A&E attendances (all scenarios)		£ 168	Curtis et al (2020)
	met/unmet needs	Hospital inpatients: average cost per episode (elective		£ 1,964	Curtis et al (2020)

		and non-elective admissions)			
	met needs	Hospital inpatients: average cost per episode (elective admissions)		£ 4,231	Curtis et al (2020)
	met/unmet needs	Hospital inpatients: average cost per episode (non-elective admissions)		£ 3,416	Curtis et al (2020)
	met/unmet needs	Outpatient services: cost per visits		£ 137	Curtis et al (2020)
	met/unmet needs	Ambulance services: average cost of call out, per incident		£246	Curtis et al (2020)
	met needs	Intermediate care step-down (residential) no of stays £576	We assume 14 days stay	£ 686	Curtis et al (2014)
	met needs	Intermediate care step-down (community) no of stays (£212)	We assume 14 days stay	£ 250	NICE (2017). Guidelines on Intermediate care
	met/unmet needs	Speech and language therapist	one hour, Band 6 @ £48	£48	Curtis et al (2020)
	met/unmet needs	Cognitive assessment	one hour, Band 7 @£58	£ 58	Curtis et al (2020)
	met/unmet needs	Vascular assessment	one hour, Band 7 @£58	£ 58	Curtis et al (2020)
	unmet needs	Taxi fare to housing office/hotel	Taxi fare for average journey: £13.5	£ 14	www.standard.co.uk/news/transport/taxi-prices-tfl-uber-black-cab-london-a4312886.html
Housing [specialist support,	unmet needs	Staff time: Referrals, Contacts and appointments, meetings	~10 hours per week. We assume 5 hours per week per case for case officer (£15 per hour) plus 5 hours on management time (£46 per hour).	£305	Expert opinion

either statutory or voluntary]		with other agencies, etc per week			
	met needs	Staff time: Referrals, Contacts and appointments, meetings with other agencies, etc per week	~10 hours per week. We assume 5 hours per week - mix of case officer and outreach (2.5 office worker and 2.5 hours; outreach - outreach less paid but should be the same; £15 per hour) plus 1.5 days on management time (£46 per hour). Expert by experience to be part of the team. Having peers experience within outreach teams, mental health teams and drug teams helps it gives a raw model that they can refer to.	£ 535	Expert opinion
	met/unmet needs	Need assessment	4 hours to include everything, preparation, assessment and post assessment, £15 per hour * two people required.	£120	Expert opinion
	unmet needs	Personal housing plan: cost per week	2 hours per week for the whole period they stay in the accommodation (one staff, coordinator officer salary £15 per hour)	£ 30	Expert opinion
	met needs	Personal housing plan: cost per week	2 hours per week for the period they stay in the accommodation for 3-4 people: Housing officer (applying legal framework £15 per hour), rough sleeper worker (outreach and I reach£15 per hour), coordinator officer £15	£ 90	Expert opinion
	met needs	Housing review: cost	Senior officer manager - 2 days about £150 per day	£ 300	Expert opinion
	unmet needs	Temporary accommodation: no of nights	"occasionally" defined as ~ 2 days a week for the period indicated in the chronology		Expert opinion
	met/unmet needs	Temporary accommodation: cost per week	Average Housing Benefit plus additional spend on supported Housing Benefit for single homeless people	£ 309	DWP and DCLG (2016) Supported accommodation review: The scale, scope and cost of the supported housing sector, p.53: “Working-age claimants in Specified Accommodation average Weekly Housing Benefit award” (£173/

					week) plus p.64: "Estimated additional spend on supported Housing Benefit for single homeless people" (£177.5m per annum / estimated 30,000 single homeless people = £114 / week)
	met needs	Own tenancy (social, private, or shared accommodation): no of nights	moved to own tenancy from March 2015		expert opinion
	met needs	Own tenancy (social, private, or shared accommodation): cost per week	"Housing benefit – average weekly award, across all tenure types" – average weekly award for single person with no dependents	£ 96	Greater Manchester Combined Authority (2019), Unit Cost Database
	unmet needs	Food and bedding		£ 30	Expert opinion
	unmet needs	Taxi fare to probation appointment/accommodation	Taxi fare for average journey: £13.5	£ 14	www.standard.co.uk/news/transport/taxi-prices-tfl-uber-black-cab-london-a4312886.html
Adult social care / Safeguarding	unmet needs	Adult Safeguarding: Referrals, Contacts and appointments, meetings with other agencies	Cost per person referred, average £620, about 14 hours, Including: Social worker practitioner plus senior practitioner and team managers	£ 620	Expert opinion
	unmet needs	Adult Safeguarding: staff time	~ 1 hour staff time per event in the chronology (assessments; meetings, referrals, etc including face to face and indirect time); based on average social services staff time (Curtis et al, 2020)		Expert opinion

	unmet needs	Adult safeguarding: staff cost per hour	Average salary for the team: Costs include wage/salary; salary oncosts; overheads; capital costs (based on social work practitioner calculations see Curtis et al 2020)	£ 46	Expert opinion
	met needs	Adult safeguarding: conducting section 42 enquiry	Duration 6 weeks, staff time: 2 days a week (for the team); staff salary: average £46 per hour.	£ 4,140	Expert opinion
	unmet needs	Social worker time (Referrals from/to other agencies; Contacts and appointments (attended /missed) with the person; meeting with referrals to other agencies)	4 hours per week: Based on total minutes spent on a case of an adult who self-neglect over a four-week period for 'high' intensity cases (social worker 3 hours) plus one additional hour for indirect time	£ 184	Expert opinion
	met/unmet needs	Social worker costs per hour	Costs include wage/salary; salary oncosts; overheads; capital costs (see Curtis et al 2020)	£46	Social worker (adult services); Curtis et al (2020)
	unmet needs	Independent medical advisor assessment; cost per assessment	60 minutes	£120	Curtis et al (2020)
	met/unmet needs	Hospital social work practitioners: staff time	~ 1.5-hour staff time per event in the chronology (assessments; meetings, referrals, etc including face to face and indirect time). Costs include wage/salary; salary oncosts; overheads; capital costs (see Curtis et al 2020)	£ 69	Expert opinion
	met needs	Community Outreach Officer: staff cost per hour	Average wage: £25,000 per annum; 3 hours per week	£ 33	https://jobs.communitycare.co.uk/
		Community Support Worker: time	from august 15th on/off (1 hour per week) JN; Average wage: £25,000 per annum	£ 33	Curtis et al (2020)
	met needs	Care package: Home Care Services (hours per week)	14 hours per week		Expert opinion
	met needs	Care package: Home Care Services (home care worker hourly cost)	£24 per weekday hour (£25 per day-time weekend, £25 per night-time weekday, £25 per night-time weekend). 2019 prices	£ 25	Curtis et al (2020)

	met needs	Care package: Meals on Wheels (per week)	£46 average per week (2013 prices)	£ 54	Curtis et al (2014)
	met needs	Care package: Key safe		£ 66	Age UK (2021) https://personalalarms.ageco.co.uk/pages/key-safe
	met needs	Care package: Nursing Home	£599 per resident week	£ 1,291	Curtis et al (2020)
	unmet needs	Community Protection Notice	per Notice	£ 484	Home Office (2018) Reform of anti-social behaviour powers: Community Protection Notice, Community Protection Orders and the Community Trigger. £450 (2017 price)
	unmet needs	Care home dementia unit (3rd January until 28t h May 2019), days	Care home dementia unit (3rd January until 28th May 2019), days	£145	Curtis et al (2020)
	unmet needs	Community safety and enforcement officer: time	an hour per visit		Expert opinion
	unmet needs	Community safety and enforcement officer: staff cost per hour	Average wage: £25,000 per annum	£33	https://jobs.communitycare.co.uk/
Mental Health Services	unmet needs	Mental Health Hospital Liaison Services: cost per contact	1.5 hours per person with recovery worker (£15 per hour) plus 1.5 hour with band 4 (hourly rate £40) plus 1.5-hour forensic psychologist (£60 per hour) plus1.5 hours psychiatrist (£35 per hour) including antipsychotic medications and methadone. This would include both direct and indirect time.	£135	Expert opinion
	met needs	Mental Health Hospital Liaison Services: cost per contact	2 hours per person with recovery worker (£15 per hour) plus 2 hours with band 4 (hourly rate £40) plus 2 hours forensic psychologist (£60 per hour) plus 2 hours psychiatrist (£35	£180	Expert opinion

			per hour) including antipsychotic medications and methadone. This would include both direct and indirect time.		
	met/unmet needs	Mental Health Hospital Liaison Practitioner; Staff time (referrals, meetings, preparation time)	band 4 hourly rate (per each hour contact time = 1-hour indirect time)	£32	Expert opinion
	unmet needs	Community mental health services: cost per contact	Cost per contact with Generic CMHTS (face to face and non-face to face) (£163); Community Mental Health Teams – Unit Costs 2016/17	£182	NHS Benchmarking network (2018) NHS England Community Mental Health Services Audit Results
	unmet needs	Community mental health services: Staff time (referral letters, meetings and preparation time)	Nurse band 6 hourly rate; Cost per hour of patient related work	£49	Curtis et al (2020)
	met needs	Community mental health services: Staff time (referral letters, meetings and preparation time)	Only assessment (see unmet need scenario). No additional time. with community mental team would be needed. If someone is admitted to hospital mental health services would push for the person not to be discharged on the street.	n/a	Expert opinion
	met/unmet needs	Mental health assessment on the street– this establishes the presence or absence of a mental disorder as defined in the Mental Health Act 1983.	Someone complex may have two reviews with psychiatrists on the street (two hours total). It would be a consultant psychiatrist plus one independent section 12 doctor (£175 per assessment) Or sometimes 2 independent doctors per £175, plus private ambulance for mental health work, two police officers (three hours), Time for police processing request for assistant (one hour), time for service administrator processing referral, plus social worker time (3 hours).	£736 (plus, police: £90, plus social care: £46*3)	Expert opinion
	met/unmet needs	Mental health assessment in the hospital – establishes the presence or absence of a mental disorder as	only one independent doctor, £175	£ 175	Curtis et al (2020)

		defined in Mental Health Act 1983. This assessor is required to be equivalent to a Section 12-approved doctor under the Mental Health Act			
	met/unmet needs	Mental capacity assessment –establishes whether the individual lacks the capacity to consent to the arrangements proposed for their care	Assessment by mental health assessor is consultant psychiatrist /senior social worker average £103	£ 103	Curtis et al (2020)
	met/unmet needs	Eligibility assessment – establishes the individual's status or potential status under the Mental Health Act with the aim of confirming whether the individual should be subject to the Mental Health Act or the DoLS under the Mental Capacity Act 2005	Assessment by mental health assessor is consultant psychiatrist /senior social worker average £103	£ 103	Curtis et al (2020)
	met/unmet needs	No refusal assessment – establishes whether authorisation of deprivation of liberty would conflict with other authorities (eg power of attorney) for decision-making for individual.	Assessment by senior social worker average £67	£ 67	Curtis et al (2020)
	met/unmet needs	Deprivation of liberty	£2200 (these are only the assessment costs; Curtis 2020). Full costs average 30,630	£30,630	Local GOVERNMENT LAYER.CO.UK (2011).

					Costing the deprivation of liberty safeguards
Voluntary sector [non statutory support work, including assessment and community support]	unmet needs	Staff time	~ 2 hours per month		(Anka et al. 2017)
	unmet needs	Assessment and support plan	Half day session from outreach team, senior practitioner (£180 per session). But often if someone is not engaging there would be multiple visits - several days of senior practitioner input across several months. Average: Initial assessment – 2 to 6 half day sessions. (Based on Enabling Assessment Service London)	£ 180	Expert opinion
	met needs	Assessment and support plan	2 half-day sessions (£180 per session). One half day session of a senior practitioner, plus one half day session for ongoing case discussion. Outreach reports the case to voluntary organisation, and they do the assessment; following that the voluntary organisation joins monthly discussion of the case with the outreach team and provides more advice.	£ 360	Expert opinion
	met needs	Staff time	~ 3 hours per week		Expert opinion
	met/unmet needs	Staff costs per hour	based on bhcommunityworks.org.uk; Costs include wage/salary; salary oncosts; overheads; capital costs.	£29	Wages extracted from www.statista.com/statistics/280687/full-time-hourly-wage-uk/ £25.22 to £33: ~ average of £29

Appendix 3: Sensitivity Analysis

We calculated the difference between the budget needed to deliver the 'met needs' scenario minus the budget needed to deliver the 'unmet needs' scenario and we compared possible change in estimates when varying:

(a) The costs of the 'unmet needs' scenario (while we kept constant the budget for the 'met needs' scenario). We varied one budget line a time by a predefined amount (+25, +50, +75 and +100%) and kept the others constant, and then we varied them all (by the same percentage).

(b) The costs of the 'met needs' scenario (we kept constant the budget for the 'unmet needs' scenario). We applied a similar methodology outlined above.

Table A1: Howard (12 months): Difference between met and unmet needs' scenario

(a) when we vary each item of costs for the unmet needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	24,193	23,862	15,831	20,465	22,305	24,023	24,281	8,224
(+50)	23,931	23,268	7,206	16,474	20,153	23,590	24,106	-8,007
(+75)	23,668	22,674	-1,419	12,483	18,002	23,156	23,932	-24,239
(+100)	23,406	22,080	-10,044	8,492	15,851	22,723	23,757	-40,471
Original analysis	24,456	24,456	24,456	24,456	24,456	24,456	24,456	24,456

(b) when we vary each item of costs for the met needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	24,560	25,686	29,127	32,925	31,407	24,500	25,332	46,801
(+50)	24,665	26,916	33,798	41,394	38,358	24,543	26,208	69,147
(+75)	24,770	28,146	38,469	49,863	45,309	24,587	27,084	91,492
(+100)	24,874	29,376	43,140	58,332	52,260	24,631	27,960	113,838
Original analysis	24,456	24,456	24,456	24,456	24,456	24,456	24,456	24,456

*Health [either elective or non-elective treatments]
**Housing [specialist support, either statutory or voluntary]
*** Voluntary sector [non statutory support work, including assessment and community support].

The green colour means that the investment to be made to fund the 'met needs' scenario is < (less) than that required to fund the unmet needs' scenario; otherwise: the investment to be made to fund the 'met needs' scenario is > (greater) than that required to fund the 'unmet needs' scenario. The yellow colour means that the additional investment is between 0 and what proposed by the baseline analysis (£24,456). The red colour means that more investment is needed than that anticipated in the baseline analysis (> than £24,456).

Table A2: Jonathan (12 months): Difference between met and unmet needs' scenario

(a) when we vary each item of costs for the unmet needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	-34,536	-30,248	-39,430	-34,419	-32,927	-30,426	-30,492	-50,993
(+50)	-38,825	-30,248	-48,613	-38,591	-35,607	-30,605	-30,737	-71,739
(+75)	-43,113	-30,248	-57,795	-42,762	-38,286	-30,784	-30,981	-92,484
(+100)	-47,402	-30,248	-66,978	-46,934	-40,966	-30,963	-31,226	-113,230
Original analysis	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248

(b) when we vary each item of costs for the met needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	-28,677	-30,248	-25,695	-27,828	-26,723	-30,204	-29,175	-17,064
(+50)	-27,106	-30,248	-21,142	-25,409	-23,198	-30,160	-28,103	-3,880
(+75)	-25,535	-30,248	-16,589	-22,990	-19,673	-30,116	-27,030	9,304
(+100)	-23,964	-30,248	-12,036	-20,570	-16,149	-30,073	-25,958	22,487
Original analysis	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248	-30,248

*Health [either elective or non-elective treatments]
**Housing [specialist support, either statutory or voluntary]
*** Voluntary sector [non statutory support work, including assessment and community support].

The green colour means that the investment to be made to fund the 'met needs' scenario is < (less) than that required to fund the unmet needs' scenario. The yellow colour indicates that the investment to be made to fund the 'met needs' scenario is > (greater) than that required to fund the 'unmet needs' scenario.

Table A3: MS (12 months): Difference between met and unmet needs' scenario when we vary:

(a) when we vary each item of costs for the unmet needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	-40,079	-39,965	-41,683	-43,685	-45,977	-48,816	-40,632	-61,049
(+50)	-40,194	-39,965	-43,402	-47,405	-51,989	-57,668	-41,298	-82,133
(+75)	-40,308	-39,965	-45,120	-51,125	-58,002	-66,520	-41,965	-103,217
(+100)	-40,423	-39,965	-46,838	-54,845	-64,014	-75,371	-42,632	-124,300
Original analysis	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965

(b) when we vary each item of costs for the met needs' scenario by a given percentage

	Criminal justice, £	Drug & Alcohol, £	Health*, £	Housing**, £	Adult social care/ Safeguarding, £	Mental Health, £	Voluntary sector***, £	All items of costs, £
(+25)	-39,965	-39,965	-39,199	-37,651	-33,299	-39,764	-38,819	-28,872
(+50)	-39,965	-39,965	-38,433	-35,337	-26,632	-39,563	-37,672	-17,779
(+75)	-39,965	-39,965	-37,667	-33,023	-19,966	-39,363	-36,526	-6,686
(+100)	-39,965	-39,965	-36,901	-30,709	-13,300	-39,162	-35,380	4,406
Original analysis	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965	-39,965

*Health [either elective or non-elective treatments]
**Housing [specialist support, either statutory or voluntary]
*** Voluntary sector [non statutory support work, including assessment and community support]

The green colour means that the investment to be made to fund the 'met needs' scenario is < (less) than that required to fund the 'unmet needs' scenario. The yellow colour indicates that the investment to be made to fund the 'met needs' scenario is > (greater) than that required to fund the 'unmet needs' scenario.

DOI: : 10.21953/LSE.ADWYK980XM9I

Care Policy and Evaluation Centre (CPEC)

Telephone
+44(0)20 7955 6238

Email
Cpec@lse.ac.uk

Address
London School of Economics and Political Science,
Houghton Street,
London, WC2A 2AE