An Independently Conducted Ethnographic Service Evaluation

‘Observing people in their own environment to understand their experiences, perspectives and everyday practices.’



A closer look at Early Support Hubs for Young People in Southampton

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Purpose of this report

This report provides an accessible account of how the No Limits model works in practice, drawing on data gathered in 2025. It describes the organisation's history, service model, workforce, trusted relationships, safeguarding, system integration, youth participation, approach to outcomes, and the structural pressures it navigates. It is intended to support organisational learning, explain the model to partners and commissioners, and identify strengths and implications for the wider development of Early Support Hubs.

How to read the report

- The report is based primarily on focused ethnographic observation, interviews with staff and young people, documentary material, and confirmation checking with the organisation.
- Its purpose is interpretive: to explain the model, how care is organised, and what appears to support safe, accessible, and relational practice.
- It is not an economic evaluation, performance audit, clinical effectiveness trial, or comprehensive quantitative assessment of service outcomes, and it does not seek to determine whether No Limits produces particular outcomes relative to another model of care.
- The report includes both strengths and tensions of the model of care. The tensions are presented to support reflection and system learning.
- Quotations and examples have been anonymised and, where necessary, generalised to protect the confidentiality of young people and staff.
- Findings describe the service as it operated during the 2025 fieldwork period; contracts, pathways, staffing, and service arrangements may subsequently have changed.

About the author

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Ethnographic Service Evaluation Report

No Limits: An Early Support Hub for Young People in Southampton

Executive Summary

No Limits is a voluntary sector organisation providing drop-in advice and guidance, counselling, drug and alcohol support, employment assistance, sexual health services, and a substantial portfolio of NHS-funded and embedded provision for young people in Southampton and across Hampshire and Portsmouth.

Its core drop-in and youth work provision serves young people aged 11 to 25 in Southampton city. Its counselling service extends more widely across Hampshire, Southampton and Portsmouth, providing services for children and young people aged 5 to 25, with extended eligibility for young people with special educational needs and disabilities and for care leavers. During the fieldwork period, the organisation also opened a second, neurodiversity-friendly and sensory-aware hub for young people aged 11 to 17 in a suburban area of Southampton.

No Limits is best understood as a youth work-led, non-clinical hub with extensive integration, developed over many years, into NHS crisis, triage, counselling, and community mental health pathways. It provides a deliberately non-clinical and relational front door, supported by robust safeguarding, qualified therapeutic provision, and established referral pathways into statutory health and emergency services. Youth work values and relational practice sit at the centre of the organisation's identity, with counselling, drug and alcohol support, and other specialist services embedded within that framework rather than driving it. Staff describe their role as becoming a jack of all trades for young people with multiple overlapping needs, offering continuity, advocacy, and practical assistance that is often difficult to provide within more specialised or time-limited statutory service models. Its distinctive contribution is to provide a trusted, non-clinical entry point for young people while maintaining robust safeguarding, clinical supervision, and escalation pathways into CAMHS, emergency departments, NHS 111, police, ambulance services, and other local partners when more specialised or urgent intervention is required.

No Limits' principal strengths are its open-access model, the breadth of its service offer, its strongly relational staff culture, and its capacity to hold high levels of risk without excluding young people from the service. These strengths rest on a wider foundation of formal system integration that has developed cumulatively over decades rather than through a single contract: community counselling contracts for children and young people; consortium leadership across ten delivery partners; A&E Navigators across five emergency departments; follow-on social prescribing after emergency attendance; a youth worker and social prescriber embedded within the CAMHS Single Point of Access; a role within Hampshire 111 mental health triage; three out-of-hours Safe Havens; and mental health support for young people aged 16 to 25 navigating major life transitions.

Its principal tensions are the intensity of need among a subset of regularly attending young people with complex and higher-risk needs, growing housing and homelessness pressures that exceed what any advice service can resolve, variation in how consistently integration with external services translates into smooth coordination for individual young people, and the risk of absorbing unmet need from a wider local authority and statutory system experiencing significant resource pressures. These tensions are structural rather than operational. They reflect the position No Limits occupies within a fragmented youth support system, where it has become one of the few consistently available, open-access sources of continuity for some of the city's most marginalised young people.

How was this Service Evaulation developed?

This evaluation was developed from one case within a comparative doctoral study of three large, well-established Early Support Hubs in England. The organisations were selected as contrasting cases to examine how mature hub models organise access, relationships, safeguarding, workforce, service integration, and support for young people with complex and intersecting needs.

At No Limits, focused ethnographic fieldwork was conducted across two intensive one-week periods in June and July 2025 and included 67 hours of direct observation, six formal interviews involving seven staff participants, two interviews with young people, informal conversations, and documentary analysis of organisational materials and de-identified case studies.

Findings were subsequently checked and refined with senior No Limits staff. Ethical approval was granted by the University of Oxford Central University Research Ethics Committee (CUREC 2, reference R95612/RE001). The doctoral analysis was conducted independently as an interpretive case study; the Youth Access Quality Framework was subsequently used as an organising lens for translating findings into this service-facing evaluation. All quotations retained in this report are anonymised and identified by role code only, and potentially identifying contextual details have been removed or generalised.

1. Service History, Geography and Development

No Limits began in 1993 as a drop-in centre offering information, advice, and guidance for young people aged 13 to 25 in Southampton. Over the following three decades it expanded substantially as successive rounds of funding enabled the development of counselling services, a reduction in the counselling age threshold to five years old, extension of provision across Hampshire and Portsmouth, and the development of specialist services in drug and alcohol support, sexual health, and employment. In 2019 the organisation formed a significant NHS partnership, placing youth workers as A&E Navigators in hospital emergency departments; that partnership has since grown to cover five emergency departments across Hampshire, Southampton and Portsmouth. The number of drop-in locations has varied over time, from three city sites to a single central hub, with a second neurodiversity-friendly site for younger adolescents opening during the fieldwork period.

Over time, No Limits has also developed a substantial portfolio of NHS-funded and integrated provision. This includes leadership of a ten-partner consortium delivering community counselling and youth wellbeing support across Hampshire, Southampton and Portsmouth; youth workers embedded as A&E Navigators across five emergency departments; follow-on social prescribing for young people presenting in crisis; involvement in Hampshire 111 mental health triage; a youth worker and social prescriber embedded within CAMHS Single Point of Access; three out-of-hours Safe Havens; and mental health support for young people aged 16 to 25 navigating major life transitions. These arrangements have accumulated through long-term partnership development rather than through the implementation of a single integrated hub contract.

The central Southampton hub is located on a busy high street and operates as a multifunction space. Brightly coloured chairs surround circular wooden tables. Hanging plants adorn the entrance. Young people move through the space continuously: some seeking advice or emotional support, others using the laundry facilities, shower, or food supplies, or simply sitting somewhere warm. The hub provides a range of practical survival resources alongside its formal service offer, including showers, laundry, clothing, and food, described by staff as essential for stabilising young people experiencing street street homelessness before they can engage with other forms of support:



> *Having the sofa bed, the laundry, the shower with toiletries, and our food... especially for young people experiencing street homelessness. (S3-ST-019)*

This staff quote illustrates how No Limits treats material need as inseparable from emotional and relational support, providing a baseline of physical stability that makes engagement with other services possible.



The second site, opened during the ethnographic fieldwork period, serves a quieter, more suburban catchment area close to primary and secondary schools. Its interior is deliberately softer and more sensory-aware than the central hub, with carpeted floors, soft furnishings, and sensory toys designed to reduce stimulation and create a more accessible environment for younger, neurodivergent, or developmentally vulnerable young people. The two sites reflect an explicit spatial strategy: a loud, high-capacity central hub offering a wide range of services alongside a quieter satellite designed to lower the threshold for first contact and build trust that can then be carried into the busier central site.

Senior managers described the importance of geography in shaping who accesses services and what kinds of provision become possible in different locations:

> *Geography really matters... if you're based within their community, you are going to get a different group. (S3-ST-016/017)*

This observation shaped decisions about where to locate services, which hours to open, and how to design physical spaces. Opening hours were extended following direct consultation with young people about when they most needed support. The hub now opens for approximately forty hours per week, including evenings until 8 pm on several weeknights and Saturday mornings. This recognises that crisis does not conform to office hours, and that young people in work or education can only attend outside conventional service times. One experienced youth worker described the value of visibility during evening hours:

> *Young people might be out thinking about doing something more negative... and they walk past and see we're open. (S3-ST-020)*

Young people themselves described No Limits as filling a distinctive social role in the city, a third place between work and home that offers connection without the pressures of commercial spaces. One young person reflected on what the hub provided in the context of vanishing youth infrastructure across Southampton:

> *These places are dying out... youth clubs are a thing of the past... but here, you can get that. (S3-YP-001)*

This account points to a gap in service provision for young people that No Limits has grown to occupy. No Limits has developed from a modest advice centre into a substantial and multi-stranded regional hub, shaped by geography, community need, and ongoing consultation with the young people it serves. Its current form reflects three decades of adaptation to a population whose needs have grown in complexity and whose access to alternative support has narrowed.

2. A Non-Clinical and Trusted Front Door

No Limits provides a deliberately non-clinical and relational front door, supported by robust safeguarding, clinical governance, qualified therapeutic provision, and established pathways into statutory health and emergency services. This combination—accessible entry without sacrificing safety or system connection—is a particularly important feature of the model and is examined across the sections that follow.

No Limits operates an open access model. Young people arrive through self-referral, informal word of mouth, signposting from schools, health visitors, and other services, and through formal and informal NHS direction. There is no eligibility threshold based on diagnosis. The drug and alcohol service is explicit that it will work with anyone within the age range who consents to engage. The drop-in service itself is walk-in, with no requirement for prior registration or referral, though young people complete an initial feedback and registration form at first contact with a worker present to support the process. The drop-in itself functions as the primary coordination hub for young people's experience of the organisation. Staff manage flow, triage informal need, and maintain awareness of who is in the space at any given time. The locked front door with glass frontage is a spatial expression of this: staff and young people can see one another before entry, allowing staff to manage entry safely while maintaining visibility and welcome.

No Limits does not present itself primarily as a clinical service, unlike some early support hubs that seek closer alignment with clinical frameworks and statutory services. Professional identity is grounded in relational practice and youth work principles rather than clinical hierarchy. Staff clothing is casual and comfortable, presented as an intentional choice that reduces the distance between worker and young person. A staff member described the importance of this for their experience working at No Limits:

> *At No Limits I feel like I don't have to pretend... I can be myself. If a workplace makes staff feel they can be themselves, then they're more likely to build trusting, meaningful, supportive and professional relationships with young people. (S3-ST-002)*

The absence of formal professional signals in dress and presentation is a deliberate relational strategy that communicates accessibility to young people who may have had negative experiences of formal institutional settings.

The physical environment of the hub is a trust-building structure in itself. The brightly coloured chairs, the hanging plants, the food and drink freely available, the laundry and shower facilities, and the locked door with glass frontage that allows young people to be seen before they enter are all deliberate design choices that communicate something about what kind of place this is before any conversation begins.

3. Workforce, Supervision and Scope of Practice

No Limits' professional culture is strongly shaped by youth work values and identities. Youth work is understood by the organisation as central to its ethos, and the capacity to build informal trust and sustain relational engagement is regarded as foundational, alongside the technical knowledge required for advice and specialist roles. Many staff first encountered the organisation as volunteers before joining in paid roles, a recruitment pathway that produces a workforce already familiar with the organisational culture and the young people who use the hub:

> *The youth work side is more important to us than the advice side... it's harder to teach those skills. An ability to talk in a relaxed way that appears to be about nothing, but isn't about nothing. Most of our team started as volunteers... they've seen the culture, seen the young people, and they're the ones that stay. (S3-ST-017)*

This reflects a deliberate recruitment philosophy that places substantial weight on relational capability, youth work values, authenticity, and the ability to work safely and respectfully with young people. These qualities sit alongside the qualifications required for specialist roles and contribute to organisational continuity and loyalty.

The counselling service is intentionally pluralistic, drawing on integrative, cognitive behavioural, and family therapy approaches, alongside practitioners trained in youth work and social work. The therapeutic lead described the counselling model as deliberately broad and flexible, able to be offered on either a short- or long-term basis depending on the needs and preferences of the young person. The drug and alcohol service operates with minimal eligibility criteria, working with any young person aged 11 to 25 who consents to engage, regardless of the severity or type of their substance use. Employment support, sexual health clinics, and outreach in accident and emergency departments complete the service portfolio.

Staff describe the team culture as collegiate, mutually supportive, and attentive to the emotional demands of the work. Vicarious trauma and the weight of working with high levels of crisis, deprivation, and risk are openly acknowledged. The therapeutic lead regularly reminds staff to take breaks and annual leave, and managers are described as checking in on staff as people rather than solely as workers:

> *Here we are a very close-knit team... we come through crisis together. Managers care about us as people, they check in, they give us time, they support us. (S3-ST-002)*

This culture of mutual support is directly connected to staff retention and the sustainability of relational practice over time.

A wider workforce infrastructure sustains safe and skilled care. Youth work is treated as a skilled professional practice in its own right, rather than as a substitute for clinical provision. Relational capability is deliberately recruited and cultivated, and staff receive baseline mental health and safeguarding training regardless of role. The multidisciplinary workforce includes counsellors, youth workers, social workers, drug and alcohol practitioners, social prescribers, and youth wellbeing practitioners. This professional diversity is matched by extensive operational, clinical, and external supervision. Staff wellbeing and retention function as prerequisites for continuity and trust, and the organisation's reach depends on workers able to move between practical, relational, and system-navigation tasks.



Supervision structures are described as more extensive than those in statutory settings, explicitly acknowledged as necessary given the scale of risk that staff carry. The therapeutic lead, drawing on prior experience as a senior leader in school education, has applied a strong emphasis on formal oversight and both operational and clinical supervision, including external supervision arrangements. This commitment to supervision is understood not merely as a quality assurance mechanism but as a structural support for staff who regularly hold significant clinical and safeguarding risk:

> *We've got an enormous amount of supervision, more than you'd get in statutory services... it's important because we carry an enormous amount of risk. (S3-ST-018)*

Quality assurance in the counselling service occurs through registration or accreditation with the British Association for Counselling and Psychotherapy or another relevant professional body, continuing professional development requirements, external clinical supervision, and feedback from young people. The therapeutic lead, reflecting on the difference between school-based audit cultures and counselling quality assurance, noted that counselling practice is not directly observable in the way that classroom teaching is, placing greater weight on supervision and feedback loops as quality mechanisms:

> *With counselling, unlike teaching, there's no observation... so it's harder to measure quality... you rely on supervision and feedback loops. (S3-ST-018)*

This framing positions supervision, rather than standardised measurement, as the primary quality assurance mechanism for the counselling service, a question considered further from an outcomes perspective in Section 8.

The Individual Placement Support employment programme, introduced during the fieldwork period, is a notable example of how No Limits formalises and funds work that has been occurring informally within the service. Youth workers had already been supporting young people with CVs, interview preparation, and job searching within a weekly group. The formal programme made this visible as a named service component, adding structure and designated funding without significantly changing the underlying practice. From the outside, and particularly from a commissioning perspective, this may read as the introduction of a new model. What it represents in practice is the recognition of adaptive work responding to young people's needs that had long been embedded within the service. This pattern of formalising existing good practice rather than introducing new interventions is a broader feature of how No Limits develops, and it reflects the organisation's capacity to respond to young people's needs before formal funding structures are available.

4. NHS Contracts, Embedded Roles and System Integration

No Limits' integration with the NHS extends beyond receiving referrals or signposting young people onward. The organisation holds and leads NHS-funded services across counselling, crisis response, social prescribing, and mental health triage. Youth workers are embedded within emergency departments and the CAMHS Single Point of Access, and No Limits participates in weekly multidisciplinary meetings involving CAMHS and adult mental health services through an Integrated Care Board partnership. A further pathway links the organisation with Hampshire 111 mental health triage. These arrangements place No Limits within parts of the infrastructure through which young people are assessed, supported, and routed through local services. Alongside internal case review, No Limits also contributes to external multidisciplinary decision-making for young people with complex and overlapping needs, including weekly ICB-linked meetings and a youth justice joint decision-making panel. These forums bring together youth work, mental health, substance use, social care, and justice perspectives around individual cases, reducing reliance on sequential referrals between disconnected services.

Staff have also developed working relationships with youth justice services and with other substance use organisations operating in the area. The drug and alcohol team manager participates in a youth justice joint decision-making panel, described as an unusually productive forum for multi-agency working:

> *I sit on the youth justice service joint decision-making panel. It's very rare to get all those specialists in a room, it's really good multi-agency working. (S3-ST-022)*

This forum enables coordinated responses to individual young people that would not be possible through referral letters alone, and represents a model of multi-agency integration that No Limits has cultivated deliberately.

Formal integration did not remove all friction. Staff continued to experience variability in referral thresholds, acceptance decisions, information sharing, and the capacity of statutory services to retain responsibility for young people with complex needs.

Some young people attending No Limits are supported by CAMHS workers who are aware of and in contact with the hub, enabling coordinated responses to crisis. Others arrive after a CAMHS pathway has ended or after a referral has not resulted in ongoing support.

Housing and homelessness represent the most persistently named structural challenge across interviews and observations. When staff were asked what they would prioritise with new funding, housing provision consistently took priority over expanding the hub itself. The framing reflects the staff's analysis: unstable housing is not background context for young people's difficulties, it is frequently their primary driver. The drug and alcohol worker's description of navigating housing refusals is stark: Staff described housing refusals as carrying potentially severe consequences for young people already experiencing high levels of vulnerability.

The organisation has also seen growing numbers of asylum-seeking and refugee young people attending the service, often seeking practical support around housing, employment, and entitlements rather than mental health services specifically. Senior staff reflected on the complexity of understanding why this population gravitates toward practical rather than therapeutic support, raising questions of perception, language access, and community-based support systems. Young people granted refugee status but given limited time to secure employment and housing often presented in crisis, with housing instability as the precipitating factor.

Recognition from statutory partners has increased over recent years. Staff described a historical shift in how some partners understood the service, from uncertainty about its informal and relational approach toward greater recognition of its safeguarding capability and effectiveness. As this recognition has grown, referral volumes have sometimes increased without equivalent increases in funding or shared support structures. Senior managers were conscious that the organisation's accessibility could lead it to absorb unmet demand from other parts of the system without equivalent increases in funding or shared responsibility.

Engagement with general practice is limited and largely absent from the everyday experience of the young people who use No Limits. Several described significant difficulties accessing GP appointments, with the unpredictability of primary care scheduling contrasting sharply with the reliability of the hub. One young person framed the difference in terms of agency:

> *I decide when I go... the door is always going to be open... that already does something good before we've even stepped into care. (S3-YP-001)*

He went on to suggest that the gap between primary care and hub provision was not simply a problem to be managed but an opportunity for structural collaboration:

> *GPs don't have the time or energy... collaboration between GPs and hubs would reduce the burden. (S3-YP-001)*

This account shows how young people experience No Limits as accessible in a way that general practice is not, and positions the organisation as a potential system connector that could help address resource pressures and fragmentation. In practice, No Limits is simultaneously relied upon by many young people with complex mental health and socio-economic needs, operating with resources that do not always match the level and complexity of presenting need, and formally connected with parts of the statutory infrastructure its young people most frequently encounter. Strengthening formal connections with primary care represents a potential opportunity for more coherent and less fragmented support.

5. Safeguarding, Clinical Governance and Escalation

Safeguarding at No Limits rests on an organisational architecture that precedes and supports individual judgement. All staff receive baseline Level 2 mental health training, including suicide prevention training, self-harm training, and mental health first aid, and have immediate access to senior advice when concerns arise. Risk is held collectively rather than by individual practitioners, through internal case review, clinical supervision, and established external escalation pathways, with safeguarding reports subject to regular audit. Client interactions are also documented in internal digital case management systems, ensuring continuity of information across the team. This architecture is what allows the relational judgement described in the rest of this section to operate safely.

Safeguarding at No Limits operates under conditions of considerable complexity. The service supports young people with multiple and sometimes acute risk factors, including suicidal ideation, self-harm, substance use, homelessness, criminal justice involvement, exploitation, and complex or enduring mental health needs. The open-access model means that risk can arrive unannounced, sometimes without immediate access to relevant statutory records, and often while relationships are still being established.

Within the counselling service, risk is held collectively by the team: no individual practitioner carries safeguarding responsibility alone. The therapeutic lead is explicit about this as a structural principle:

> *We hold risk carefully as a team... nobody holds it on their own. (S3-ST-018)*

This collective model distributes responsibility in ways that protect individual practitioners from unsustainable burden while maintaining organisational accountability.

In the drop-in, safeguarding practice is visible in the flow of everyday interactions. In one observed case, a junior staff member responded to suicidal ideation disclosed by a young person with complex and enduring emotional needs by immediately seeking managerial guidance. The concern was taken seriously and appropriate support was arranged, including contact with the young person's existing mental health practitioner, without automatic or unnecessary escalation to crisis services. Staff described this capacity to maintain relational continuity while managing acute risk as a core strength of the hub's model:

> *It's the million dollar question... we have so many young people coming in that feel suicidal on a daily basis... sometimes they just needed some company and to be able to talk things through... that is the beauty of what this hub does. (S3-ST-020)*

The capacity to distinguish between a young person who needs to be heard and given relational support, and one who needs immediate clinical intervention and crisis escalation, is a skill in risk management that the hub has developed deliberately over time with clinical, supervisory, and senior safeguarding input. Case evidence gathered during fieldwork illustrates the potential for this kind of relational intervention to reduce demand on crisis services and accident and emergency attendances, by providing a reliable relational alternative to escalation. That potential preventive function is difficult to establish at system level from ethnographic evidence alone, but it is a function of services like No Limits that future assessments of value to the wider system should take into account.

In another case involving a potential risk to others, staff escalated concerns through the organisation's safeguarding structure and made timely, proportionate referrals to relevant external agencies. The young person was informed in advance that these referrals would occur, and they continued to engage positively with No Limits and their youth workers afterwards. The case demonstrated that transparent safeguarding action need not automatically rupture trust.

Where risk exceeds what can safely be managed within the hub, staff work with the relevant clinical and emergency services, including CAMHS practitioners, NHS crisis pathways, ambulance services, emergency departments, and community policing. Escalation is undertaken transparently wherever possible, with young people informed about what

action will be taken and why. The aim is to ensure robust safeguarding through proportionate, responsive, and coordinated intervention, while seeking wherever possible to preserve the relationship through which risk was disclosed.

Weekly multidisciplinary team meetings provide a structure for reviewing complex cases and safeguarding concerns. These meetings take place before the hub opens, creating protected time outside young people's presence. Safeguarding reports are regularly audited, and senior staff engage in active reflection on the patterns they reveal. One example of this reflective practice concerns gender differences in reporting rates. Managers noted that approximately 70 percent of safeguarding reports concerned young women, primarily around mental health, while also recognising that suicide is more prevalent in young men, prompting explicit questions about how to improve engagement with young men before crisis.

Safeguarding practice at No Limits is understood as embedded in relational trust between young people and staff. Most disclosures do not arise from formal assessment processes. They emerge from conversations that young people experience as informal, in contexts where trust has been built incrementally across multiple encounters. The managers' framing of how trust operates in safeguarding is analytically significant:

> *Most safeguarding doesn't come out of someone walking in saying something... it comes out of a conversation that for them is just a chat. Young people are evaluating us all the time... how managers talk to staff, how staff treat each other. (S3-ST-017)*

This quote captures an insight about how safeguarding functions in a relational youth work model: safety is not produced by procedure alone but by an organisational culture that young people observe and assess over time. No Limits has built safeguarding structures that are proportionate, collectively held, reflective about their own gaps, and grounded in a recognition that the conditions for disclosure are relational before they are procedural.

6. Trusted Relationships and Ethics of Care

At No Limits, an ethics of care was visible in the way staff combined attentiveness, practical responsiveness, continuity, and professional responsibility. Care extended beyond formal interventions and included remembering young people, noticing changes in behaviour, adapting communication, offering practical resources, setting boundaries without humiliation, and remaining available after difficult disclosures or safeguarding action. Staff balanced young people's autonomy with responsibility for safety and the needs of others sharing the space.

Trust is an operational foundation of the No Limits model. Without it, young people may be less likely to disclose risk, engage with advice, or return during periods of crisis. The organisation's approach to building trust is not primarily procedural. It is environmental, relational, and cumulative.

Trust builds through the accumulation of small interactions over time. Staff described success not in terms of solving problems immediately but in terms of establishing a relationship that makes young people willing to return. A good interaction might be one in which no problem was solved but the young person left feeling heard and came back the next week. This understanding of trust as the condition of possibility for all other work is embedded in how staff think about their role:

> *One of the strengths is the ability for young people to dip in and out over years. Even when they leave a project, they still know they can use the drop-in. For some, this is the longest-lasting relationship they've had. (S3-ST-016/017)*

Staff frequently used subtle, non-confrontational forms of redirection when a young person's behaviour began to affect others using the space. Rather than immediately imposing formal sanctions, workers drew on their knowledge of the individual to interrupt, redirect, or offer a practical task. These small interventions demonstrated relational knowledge developed over time, balancing the needs of one young person with those of the wider group.

In one case, a serious safeguarding concern involving family violence emerged only after several months of apparently routine practical conversations. The example demonstrated that disclosure may depend on consistency and trust rather than direct questioning alone. Trust was built through interactions that initially appeared to be about something else entirely.

Social context shapes the service in ways that are evident throughout the fieldwork. Some of the young people supported by No Limits are navigating housing instability, substance use, exploitation, racial or cultural marginalisation, and the structural constraints of systems that often assume greater stability in people's lives. Staff responses to this social context are not only individual and relational but systemic: the drug and alcohol team uses an analogy of air in the tyres of a car to convey that recovery from substance use cannot be sustained unless the other domains of a young person's life are also attended to. The comprehensive model of the hub, integrating practical, therapeutic, advisory, and social support within a single space, reflects this analysis.

The young person who described No Limits as a lifesaver captures something important about the social function of the hub:

> *Honestly,... I don't think I'd be the person I am today... No Limits has been such a lifesaver for me... every single one of the staff care about you a lot. (S3-YP-002)*

This account, like others gathered during fieldwork, is an account of the value of relational care, and what it means to a young person to have encountered a service that offered time and care, when other services may not have had the resources or capabilities to do so. The social context that brings young people to No Limits is one in which care, reliability, and being known by name are not common experiences. The service's role is partly to provide those experiences and partly, through its advocacy and outreach work, to extend them into the communities where young people live.

7. Youth Voice, Equity and Community Engagement

No Limits does not organise its provision around discrete identity categories in the same way as some hubs with dedicated LGBTQ+ or neurodiversity-specific groups. However, identity-sensitive practice runs through the service in several important ways. The neurodiversity-friendly suburban hub, opened during the fieldwork period, represents an explicit organisational response to the recognition that the sensory environment of the central hub is not accessible or comfortable for all young people. The softer layout, carpeted floors, and sensory toys of the new site are design choices that embody an understanding of neurodevelopmental diversity.

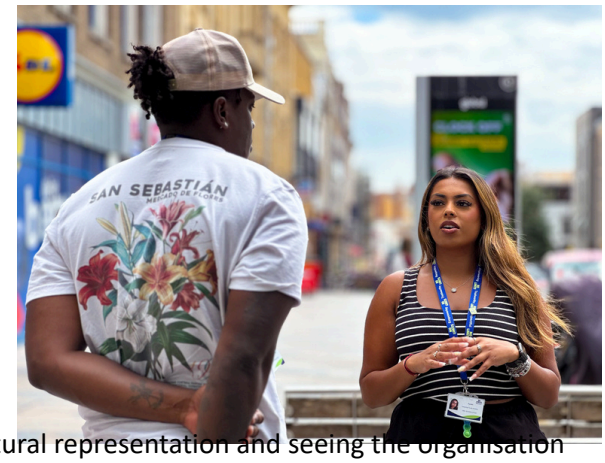
The sexual health clinic, running fortnightly at the central hub, provides a non-judgmental space for young people to access specialist support. Staff noted that the presence of different services shapes community perceptions of what the organisation does, and that the sexual health clinic had at times generated a narrow, reductive image of No Limits as primarily a sexual health service. By the fieldwork period, this perception had shifted towards a stronger association with mental health support, which staff felt more accurately represented the breadth of the offer, though they acknowledged that community perceptions remain a live consideration in how the service is understood and accessed:



> *For a period there was this thing of 'oh, you're the sex people' because of sexual health displays and clinics... now we're probably more known as the mental health people, but that perception can still be a barrier. (S3-ST-016)*

This observation highlights how the visible identity of a hub, shaped by the services it offers and the way it presents itself, affects who chooses to attend. Managing community perception is part of the work of access.

Community engagement through outreach is a feature of the organisation's identity. Observed fieldwork included an evening outreach walk with two youth workers to a Southampton area identified through community policing as a hotspot for youth antisocial behaviour. The outreach model is relational and low-key: workers move through community spaces, acknowledge young people by name, maintain a conversational presence, and make themselves visible without imposing formal service encounters. One worker used links with community sport and physical activity to engage young men outside formal service settings.



A Youth Advisory Board member described raising concerns about cultural representation and seeing the organisation respond through more inclusive communications and recognition of different cultural and religious events. They said that seeing their feedback acted upon made participation feel meaningful rather than tokenistic. The example illustrates how youth participation can become a vehicle for service-wide cultural change.

The practical community infrastructure of the hub, including food provision, laundry, showers, and clothing, represents a form of community engagement that is material rather than programmatic. These resources acknowledge that belonging and trust are built through practical reciprocity as much as through formal therapeutic encounter. The laundry cycle that keeps a young person experiencing homelessness in the building for an hour while they use washing facilities creates the conditions for a conversation that a formal appointment would not. This integration of material and relational support is a distinctive and deliberate feature of the No Limits model.

Youth participation at No Limits is structured through a youth advisory board composed of current and former service users. Several members have been involved in the national #FundtheHubs campaign, advocating for youth mental health hubs across the UK, demonstrating that participation within the organisation connects to wider civic and policy engagement. The board advises on service design and has contributed to staff recruitment decisions.

Participation is also present in more diffuse ways through the service's attentiveness to young people's accounts of what they need. The extension of opening hours to include evenings and Saturday mornings followed direct consultation with young people. The design of the new suburban hub reflected engagement with younger adolescents about what kind of space would feel accessible and safe. The youth-friendly format of the initial registration form is itself an expression of a participatory orientation, designed with young people's comfort and comprehension in mind rather than purely around organisational data requirements.

8. Outcomes, Impact and Learning

No Limits uses a range of outcome measures across its service areas. Counselling services use measures including CORE-10 and goal-based outcomes at clinically appropriate intervals, while the drug and alcohol team also uses goal-based approaches to track progress defined with young people. Other services collect feedback, service-use information, safeguarding data, case outcomes, and narrative case studies. The organisation has worked to map these measures across its different service streams and, with CORC, to develop a logic model of impact. A continuing challenge is that different forms of support appropriately measure different things. Selecting a small number of whole-organisation outcomes risks either flattening this diversity or privileging the parts of the service most amenable to standardised measurement.

At first contact, young people complete a youth-friendly feedback form with a worker present to support the process. The form uses a picture-based Likert scale to assess whether young people felt listened to, able to speak about what they needed to discuss, able to understand what was said, given ideas about next steps, and satisfied overall. The reverse side of the form collects population-level demographic data including gender, sexuality, ethnicity, GP registration, disability status, employment and education status, housing status, care experience, and other agencies involved. This dual function captures a young person's subjective experience of the service and population characteristics simultaneously, while still providing useful information about who accesses the service and their experience of support.

During fieldwork, measurement was less visible in everyday staff discussions than relational practice, crisis response, and practical support, although the organisation was continuing to strengthen its evaluation systems. This is not simply a data limitation: the breadth that makes the hub responsive also makes its impact difficult to reduce to a single common metric.

The impact culture of No Limits has historically been grounded in narrative and relational evidence alongside formal measures, and its outcomes and evaluation function is continuing to develop. Staff use documented case studies to reflect on the significance of practice and to capture changes that may be difficult to represent through common metrics. Examples included a case study in which a young person did not re-attend the emergency department during the documented follow-up period. Alongside this narrative evidence, the organisation's work with CORC and its growing impact and evaluation function point toward a more developed outcomes culture emerging alongside, rather than replacing, its relational account of impact.

9. Structural Tensions and Risks

A small group of young people required a level of continuity and structure that was difficult to provide within an unrestricted drop-in model. Staff recognised this tension and developed more structured arrangements, including named workers and agreed contact periods. Most of the young people involved continued to engage. This demonstrated both the limits of open access and the team's capacity to adapt its model while maintaining relationships.

A related tension arises from the level of clinical and safeguarding complexity that may enter through a deliberately non-clinical front door. This accessibility is a central strength of the model: young people can seek support without first obtaining a diagnosis, referral, or formal clinical assessment. However, the open-access drop-in is not itself configured as an on-site mental health assessment service, even though therapeutic expertise and clinical governance are present elsewhere within the organisation. Staff may therefore need to make immediate judgements about distress, risk, and the need for escalation while access to statutory clinical information, assessment, or formulation remains dependent on external services. Stronger and more consistently available integration with local NHS mental health teams—including timely consultation, shared assessment where appropriate, clear information-sharing arrangements, and routes to specialist review—would strengthen the model without replacing or medicalising its non-clinical front door.

Housing and homelessness represent a second structural tension that No Limits cannot resolve from within its own resources. Staff consistently identified housing as the primary driver of many young people's difficulties and the most urgent unmet need in the local system. When asked where new funding would make most impact, housing provision took priority over any expansion of the hub itself. The organisation can provide advice, advocacy, and navigation support, but cannot create housing. Staff support young people through distress generated by housing insecurity, without being able to address its underlying structural causes.

A third tension is the risk that No Limits becomes a buffer for unmet need elsewhere in the system. Staff reported that as the organisation's reputation has grown, referral volumes have increased without equivalent increases in resources or consistently clear agreements about shared responsibility. The organisation therefore faces pressure to remain accessible to young people while also defining what can safely and sustainably be provided within its remit.

The effectiveness of these arrangements depends on how consistently formal integration translates into coordination for individual young people, particularly for those also waiting for or receiving specialist mental health care. When coordination works well, embedded roles, shared meetings, and clear escalation pathways support continuity and proportionate responses to risk. When capacity, thresholds, or information-sharing arrangements are less clear, responsibility can become fragmented. This reinforces the importance of robust external integration and shared clinical governance for all Early Support Hubs providing open-access care.

Finally, the counselling waiting list remains a persistent challenge. At the time of fieldwork, young people were waiting months for counselling. Staff attempted to mitigate this through brief interventions and continued drop-in engagement, but acknowledged that waiting months for therapeutic support is too long for many young people whose needs are acute. The gap between demand and capacity in the counselling service is not unique to No Limits, but it is felt acutely within a service that positions therapeutic support as central to its core service offer.

10. Conclusions and Implications

No Limits demonstrates how a mature Early Support Hub can provide a trusted, non-clinical front door while maintaining strong safeguarding, professional governance, and extensive integration with NHS and multi-agency pathways. Its model combines youth work, therapeutic provision, practical assistance, crisis response, and system navigation in ways that reflect the complexity of young people's lives.

The service's principal strengths are its accessibility, continuity, skilled relational workforce, and capacity to adapt provision in response to emerging need. Its principal challenges arise from the wider environment in which it operates: housing insecurity, rising complexity, uneven service capacity, and the difficulty of measuring diverse forms of practical and relational work through a small set of common outcomes.

No Limits' development over more than three decades illustrates that effective hub models are built through sustained community presence and long-term partnership development. Maintaining this contribution will require stable investment, clear shared responsibilities across services, continued workforce support, timely access to NHS clinical assessment and consultation where needed, and evaluation approaches capable of recognising clinical, social, practical, and relational outcomes.