SUPPORTING PEOPLE

&

PREVENTING ANTI-SOCIAL BEHAVIOUR

Report to the Community Safety Partnership

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1. SUMMARY

1.1 Phase 3 of the Supporting People and Preventing Anti-social Behaviour (ASB) Pilot is now drawing to a close. Funded by the Community Safety Partnership (CSP) as a continuing part of extensive research originally undertaken in 2012, the pilot initially set out to test a model based on the key worker approach similar to that used by the Integrated Offender Management and Together for Families Initiative. The objective being to give a clear picture of the gaps and duplication in services from the perspective of the service user and, to develop a model of service delivery that will help reduce street based ASB associated with mental health, drug and alcohol dependency and non- engagement of services.

1.2 The original research commissioned by the CSP in in 2012 indicated that around 70 to 80 people in the city who were engaged in ASB, needing medium to high level support and who were willing to engage with support services would be best served by the proposed model. Phase 1 of the pilot was set up to test the model with 12 individuals in this cohort as a practical learning experience leading towards new ways of working with the larger group.

1.3 The pilot was extended for a further 2 years to develop models of working with this group in order to reflect the learnings from phase 1 (2014-15). A progress report was presented to the Community Safety Partnership last year.[1]

1.4 This report details how Phase 2 and 3 of the pilot has developed based on the learnings from Phase 1, the difficulties working with this cohort and the new ways of working that have been implemented as a result.

1.5 ***Next steps***

The research and pilot has given a very comprehensive picture of the situation related to street based anti-social behaviour and its attendant issues in Cambridge. The multi-agency partnership working on street life community issues, homelessness and rough sleeping has resulted in innovative and improved service provision going forward which are detailed at the end of this report.

[1] https://www.cambridge.gov.uk/sites/default/files/supporting_people_and_reducing_asb_-_update.pdf

2. BACKGROUND

2.1 The initial research carried out in 2012 identified that a few individuals appeared to be associated with a disproportionate volume of ASB, that alcohol featured in half the sample incidents, and that those individuals perpetrating street based ASB were not a homogenous group. The review identified three groups within the existing caseload and contained recommendations for working with each group. The Supporting People and Preventing ASB Pilot focused on group 2 with the review identified as consisting of;

'individuals who have higher needs in terms of alcohol, substance misuse or mental health issues. They may be living in temporary accommodation or have a street based lifestyle, but typically show a willingness to engage with support services. They may wish to enter treatment programmes and get a permanent tenancy'.

2.2 This report will detail learning from Phase 1 and how it became apparent that individuals did not fit neatly into one group. Individuals defined as typically as fitting into the middle group, group 2, could also fit into group 3;

'the smallest group, consist mostly of problematic individuals who are responsible for a significant amount of the anti-social behaviour and do not want to engage'.

Phase 3 worked with people from both cohorts and used the recommendations from previous learning to frame the objectives for this work.

3. Objectives for Phase 3

i. Continue with the work already being carried out with the remaining six on the pilot – ensuring an exit strategy was in place.

ii. Use the Task and Target meetings as a referral point where individuals involved in problematic street ASB are discussed and action plans put in place to include possible enforcement action as well as support actions. This will be monitored through the Task and Target and recorded using Ecins.

iii. Identify individuals who have sustained a tenancy long term (at least 1 year) and who are managing their alcohol/drug misuse or mental health issues and find out from them how they have done this and in particular what worked for them and what didn't. The findings to be included as part of the final evaluation / recommendation.

iv. Work with agencies to identify innovative solutions to begging and street drinking, including raising awareness of the support available to the street community, challenging and changing the commonly held misperceptions about why people beg and promoting schemes like the Alternative Giving Scheme to discourage residents and visitors from giving to beggars.

4. DELIVERING PHASE 3 - Taking into account the learning from the pilot Continue with the work already being carried out with the remaining six on the pilot – ensuring an exit strategy was in place.

4.1 Of the twelve people on the pilot, six individuals remained on the pilot into the second phase. However their engagement was sporadic. Two had accommodation in The Victoria Project, two in Willow Walk and two (a married couple) were due to be evicted from their secure tenancy due to ASB. Case Studies can be found at the end of this report in Appendix A.

4.2 The intention was to support the individuals to move through the hostel system and into their own accommodation whilst getting the help they needed to progress. Many of the participants engaged well at the beginning of the pilot, however, as movement through the system was slow they began to lose motivation. Participants often failed to carry out agreed actions, claiming, financial, health or lack of transport as reasons for not engaging. Issues such as former tenancy arrears, ID and disabilities held up the process and prevented them from moving on.

4.3 Some clients appear to have been referred to the pilot by support services as it was perceived as a quick way to move people into accommodation, although it had been made clear at the beginning that the pilot was not set up for this purpose. This resulted in de-motivation for the client when accommodation was

not quickly forthcoming.

4.4 In some cases there was pressure on the support services to move chaotic individuals into their own accommodation order to free up space for those on the waiting list who were rough sleeping. This resulted in failure in maintaining a tenancy if the individual is not fully prepared and ready to manage a tenancy.

4.5 Some participants felt that they needed support and would engage if they could get the appropriate help but that it was not accessible to them. Some had significant mental health and substance abuse issues and were struggling to manage hostel life. Whilst they did attend appointments as part of the pilot they did not follow through with any actions and little progress was made.

4.6 Only one of the individuals on the Pilot was ready to move into his own accommodation. He had successfully transitioned through the homelessness system from Jimmy's to hostel accommodation to a shared house and then into his own tenancy. In addition to being in full-time employment, he was no longer involved in crime or ASB and was well into his recovery from alcohol addiction. By the time he moved into his accommodation he was manging independently with very little support. He has since successfully completed his introductory tenancy.

5. Outcomes from the exit strategy

5.1 The difficulties faced by individuals even when they are prepared to engage and have stayed with the pilot pointed to the need for ongoing intensive support which follows the client through the system, giving them practical help in carrying out the actions they have promised to undertake. Support needs around mental ill health and dual dependency often mean a chaotic approach to managing day to day affairs and many of the individuals are simply unable to carry out actions alone and need constant practical support to achieve outcomes. Therefore, a new post, the City Street life Community Support Worker has been funded by the City Council to work as part of the Chronically Excluded Adults team. The post holder will act as the lead professional, helping to develop action plans for individuals and giving

them the customised support they need.

6. Use the Task and Target meetings as a referral point where individuals involved in problematic street ASB are discussed and plans put in place to include possible enforcement action as well as support actions. This will be monitored through the Task and Target and recorded using Ecins.

Aims of the Task and Target (T&T) Group

6.1 The aims of the Task and Target group were to coordinate information around individuals and hotspot areas and to produce multi-agency action plans to address the issues of support and enforcement. The action plans around the individual are updated monthly at the T&T and recorded on ECINS, a multi-agency information sharing database, in order to ensure a co-ordinated approach.

6.2 Action plans for individuals centre around support needs, the likely level of engagement and any appropriate enforcement, particularly where begging and drug dealing are present. Action plans on hotspot areas tend to centre on addressing the impact on the community of sleep sites and drinking areas.

6.3 As a result of the learnings from the Pilot, T&T developed to ensure that individuals were referred in as soon as they were identified as having a street presence, which could put them at risk or affect the wider community.

6.4 It had become apparent that in the majority of cases rough sleeping has an impact on the wider community in some way. Quite often reports made to support or enforcement services express concern for the rough sleeper, along with an expectation that someone will attend and take that person to a place of safety. However, it is not unusual for same reports to include a request that an area is cleansed due to the hazardous waste, including human excrement and drug paraphernalia, left in and around the sleep site.

6.5 In order to ensure that individuals are receiving the intensive customised support that they need to engage with services and progress to a point where their

behaviour is no longer having a negative impact on the community, the City Street life Community Support Worker collaborates with the T&T to develop the individual action plans. Where there is a requirement for enforcement action, the support worker will support the client through the process and ensure they are aware of the consequences of further ASB, drawing in other professionals where required.

6.6 The enforcement approach can consist of soft and hard warnings and ultimately legal sanctions, such as injunctions and community protection notices.

7. Difficulties faced by the Task and Target Group

7.1 The T&T has not been without its difficulties. Whilst attendance by agencies has been good, professionals that attend were not always able to authorise actions deemed necessary by the group, or would need to refer to another agency not in attendance. Enforcement action could not always be progressed due to reports or incidents being anecdotal rather than backed up with firm evidence. Progress could be slow. Some individuals continued to be discussed monthly with an action to, 'continue to engage with' or 'monitor.' However it could be difficult to capture what tangible steps had been taken and what constituted 'engagement.'

7.2 The majority of those discussed at T&T are still being discussed for the same issues after three months in spite of engaging with support. There is some evidence to suggest that individuals sometimes pay lip service to engagement whilst actively continuing with behaviour that impacts negatively on the community. In these circumstances enforcement action can be the way forward. However, without evidence with regards to their specific behaviour and support, it is difficult to put a case forward in order to ensure a successful outcome in Court. Where it becomes necessary to use tools such as Anti-social Behaviour Injunctions or take court action following a breach of a Community Protection Notice, anecdotal evidence is not sufficient and would only be accepted if supported by more solid evidence.

7.3 In order to address some of the issues stated above and to incorporate the work of the Rough Sleepers Working Group (RSWG) and avoid duplication, a new group,

the Streetlife Working Group (SWG) has replaced both the T&T and RSWG. This group is attended by senior Support Agency representatives who can make decisions about any provision that forms part of an individual's action plan.

7.4 The purpose of SWG remains the same as the T&T; to ensure that the most problematic individuals are managed in accordance with their needs and risk and that their behaviour no longer impacts on the wider community. The work of the CEA Streetlife Support Worker will be linked into this group and the outcomes aligned to the groups aims.

8. Identify individuals who have sustained a tenancy long term (at least 1 year) and who are managing their alcohol/drug misuse or mental health issues and find out from them how they have done this and in particular what worked for them and what didn't. The findings to be included as part of the final evaluation / recommendation.

8.1 Two potential success stories that fit the criteria of someone having successfully sustained a tenancy long term (at least 1 year) and who are managing their alcohol/drug misuse or mental health issues have been submitted. Both these individuals were interviewed and one of the transcripts is included at end of this report in Appendix A. With such a small response rate it is difficult to draw conclusions from their feedback.

8.2 However, anecdotal information gathered via different forums, such as home visits by housing and ASB officers suggest that moving into accommodation is a stressful experience particularly for someone with a street based lifestyle or who may be in recovery from alcohol or drug addictions and, in some cases, also estranged from family or support networks. Loneliness and lack of support can drive individuals back onto the streets or can see them being taken advantage of by other street life individuals looking for somewhere to stay.

8.3 More research from service users perspective about their experiences, what worked for them over the longer term and what could put them at risk of losing their accommodation again is recommended. Housing Officers, ASB Officers and other

staff who carry out home visits have a wealth of information that could be tapped into in order to find out more about where support is working longer term and where it is failing.

8.4 Housing and ASB Teams are often dealing with individuals who have held tenancies for a period of time and have managed to do so whilst causing a great deal of disruption to those living around them. Rather than focusing on what isn't working and where the gaps in provision may be, consideration ought to be given to looking into where it is working and why. We do know there are tenants that have experienced trauma such as abuse, violence or bereavement, who are managing their accommodation, who work and bring up children. Similarly we have tenants who have a mental health diagnosis, or learning difficulties but are not problematic and are able to manage their accommodation. There are likely to be functioning alcoholics and drug users who are not begging to fund their habits or involved in ASB within their community.

9. Work with agencies to identify innovative solutions to begging and street drinking, including raising awareness of the support available to the street community, challenging and changing the commonly held misperceptions about why people beg and promoting schemes like the Cambridge Street Aid to discourage residents and visitors from giving to beggars[2].

Cambridge Street Aid

9.1 Working in close collaboration, Safer Communities and Housing Advice have developed a campaign designed to discourage members of the public from giving money to people on the street, but instead to donate to a standalone fund that will be made available for local organisations to apply for on behalf of their clients. Cambridge Street Aid has the backing of Cambridge Bid, CAMBAC and local support organisations such as Jimmy's and Cyrenians.

9.2 Typically Alternative Giving Schemes receive negative media attention and have been heavily criticised for targeting a vulnerable group and stigmatising the

[2] http://www.cambscf.org.uk/cambridge-street-aid.html

homeless. Since we know that not all beggars are homeless and not everyone who is homeless perpetrates problematic street based ASB, the focus of Cambridge City Council's latest campaign is to encourage members of the public to donate their spare change to a charity that can help those on the streets turn their lives around.

9.3 Lessons have been learnt from similar schemes across the country that have received negative media coverage due to their representation of the homeless or how money given to beggars is spent. Cambridge Street Aid has moved away from making any judgements about how proceeds from begging is spent and focuses on encouraging individuals to donate to a scheme that can help people move away from a life of the streets.

9.4 Any money donated into the scheme will be managed by Cambridgeshire Community Foundation and available to support agencies to apply for grants of up to £750 to help support their client move away from a life on the streets or sustain their accommodation. It could be used to ensure an individual has the basic household items when they move into their own accommodation or to fund training or transport cost. The fund is not exclusive to one organisation, but can be applied for by any support agency working with an individual with a street background.

9.5 Cambridge Street Aid has been supported by Cambridge Bid who have given a grant of £5000 and the Safer City Scheme who have match funded. This is viewed as a long term campaign. Further details about Cambridge Street Aid, its aims and objectives are available at https://www.cambridge.gov.uk/alternative-giving-campaign. The campaign went live on 28 November 2016 with a press conference. Since then there has been a 4 week campaign of promotional materials on buses and bus tickets. Poster and window stickers have also been displayed in shops and car parks.

9.6 At the time of writing over £5000 has been donated to the fund and the support and feedback has been overwhelmingly positive. In addition, a marketing strategy

has been developed which will incorporate promoting the campaign across different thematic areas, including the student population through the University and night time economy by promoting within the venues and taxis. Links have been established with the Grand Arcade who have offered their support to the campaign.

10. Outreach Cards

10.1 In more recent months it has become common place for beggars to hold placards asking for money to access a shelter for the night. There is evidence to suggest that some of these individuals have been discussed at T&T, have been offered support and have even had a place to stay, but have not engaged. In order to ensure they are aware of the support available to them, Outreach cards have been produced, with a map detailing where they can access services, such as free food, accommodation and advice. Police, Street Outreach staff and support agencies hand out the cards to individuals rough sleeping or begging.

11. NEXT STEPS

11.1 The research and pilot has given a very comprehensive picture of the situation related to street based anti-social behaviour and its attendant issues in Cambridge. This report focuses on the outcomes from the research and pilot commissioned by the Community Safety Partnership, however the work on the pilot has linked closely with the work being carried out elsewhere by police, housing advice and support services and the partnership working of those agencies, through the Streetlife Working Group (SWG), is now in a position to move forward with innovative and improved service provision.

11.2 As mentioned previously Cambridge City Council has funded the City Streetlife Community Support Worker to deliver the customised social support needs, Housing Advice has been successful in obtaining government funding to employ a dual diagnosis team who will work with the street outreach team to deliver treatment directly to the street life community, and this team is expected to be in place by April 2017. The City Council has also funded an Enforcement Officer to work exclusively on streetlife anti-social behaviour issues. Cambridge University

and the Grand Arcade have expressed interest in working with the SWG and a number of initiatives that can benefit the streetlife community have been discussed. The gap in the service provision is a resource to co-ordinate the work with the university and businesses and to collate evidence and prepare court action cases. A funding bid to cover this resource has been submitted to the Community Safety Partnership for consideration.

APPENDIX A

Questions for success story:

1. Name
2. DOB
3. Type of accommodation (tenancy, private rented, own occupied, lodgings)
4. How did you become homeless
5. How long were you homeless
6. Where did you sleep when you were homeless
7. Did you ever have to rough sleep
8. Have you ever been addicted to drugs or alcohol – if yes, what were you addicted to?

Transcript of success story: 47 year old male

I was born in Cambridge – Mill Rd area, in care as a child and then pretty much on my own from 15. I was in and out of hostels until 18, then in and out of prison until 1991 when I met my wife. The relationship broke down in 1996 and I was broke.

I was in a state, got a heroin habit. Was homeless and sofa surfing, in and out of prison and rough sleeping in car parks – King Street. I was also shoplifting, occasional begging but I wasn't very good at it. I had depression, no support, I was on Seroxat, it made me act irrationally, and it's linked to suicide. I didn't care. I think that's why I used heroin. There are plenty of organisations and hostels that can get you off the streets If you are on the streets in Cambridge it is because you want to be. There's plenty of support out there if you want to take it. No one could help me when I was sleeping rough.

I got nicked the day before my 34th birthday and had a moment of clarity. I was in the cells withdrawing and had a vision. I was in a damp mouldy room on my own and then I was in a hospital bed surrounded by loved ones. That's what I wanted; I didn't want to die on my own somewhere.

I went to court and was bailed and scripted and then went into Jimmy's for 7 nights first then got a permanent space. I asked if I could volunteer at Jimmy's, changing beds etc. I did this for a while, I liked having something to do. Jimmy's were able to nominate someone for a flat and put me forward.

In 2004 I got a letter saying I had a property. It was my 36 birthday. When I viewed the flat the council workers were cleaning the place up. I couldn't collect the keys until they had finished, a 2-3 week wait. When I did get the keys and moved in it was exactly the same as it was when I viewed it, no cleaner.

I had a portable television, sleeping bag and a play station that someone in Jimmy's gave me. That's all. I managed to get a grant through the social fund for £1500. Barry, my support worker from Jimmy's held on to the money so I would be tempted to spend it on drugs or alcohol. I loved having my own place after being in a room with 5-6 guys. It was the best feeling. I cut myself off from all users but found myself in a funny place – normal people are reluctant to get involved and loneliness was a big problem. Coming home to an empty place is lonely.

With support from Jimmy's and a friend I got the flat decorated properly. I was off sick for 3 months as I was on methadone and it dawned on me that I wanted to work. I spoke to someone at 222 who used to organise training and they set me up with an interview. I wanted to do something; you need a purpose to get of bed.

Adam from the employment foundation linked me in with someone who offered me work 2 days a week with a tree surgeon, at the end of 3 months offered me a full-time job. I was paid £185 a week, which crippled me because I had to pay for everything. After 6-7 months training in first aid, pesticides and handling a chain saw, my money went up to £250. I was there for 7 years. I left after I started to clash with a new guy and got myself a gardening job, but left due to boredom and found work on a building site. I have been working in construction ever since. I have passed my driving test and completed loads of training – I love a course.

The longest period I have been out of work is 5 months, when I finished on the trees.

Change has to come from within; you have to want to do it. I couldn't have done it without Barry, he still helps me now. He became like a father figure to me. He's been a rock, takes me shopping, and helps me even now to manage my money. Little things make a big difference.

14 January 2016

1. Case Study 1 – Married couple at risk of eviction

The couple were referred to the Pilot because they were at risk of losing their secure accommodation. They were involved in ASB, including begging, and there were concerns that they were being exploited by others using their property. They were engaging well with the ASB officer and had spoken of their need for support as they felt they were unable to access the support they needed to manage their accommodation. Both were drug users and one had disabilities and both asserted that they were struggling with other drug users were taking advantage of their vulnerability.

The pilot co-ordinator met with them to explain what the process would involve. They were wanted to participate and openly spoke about their difficulties, which in their opinion, could have been avoided if they had the support they needed. In addition;

a. Both were heroin users and needed support to manage their addictions and wanted to be considered for alternative accommodation away from the network of drug takers / dealers around them.
b. They had their child removed due to their lifestyle which they said had a huge impact on their mental/ emotional well-being.
c. They both suffered with depression and anxiety and were self-medicating with drugs/ alcohol.
d. They had been issued with a notice of seeking possession and were at risk of losing their home.
e. Mrs had disabilities that impaired her mobility.

The coordinator explained that their role wasn't to support the individuals or to guarantee they were re-housed, but to coordinate the process and identify any potential gaps in support, which if plugged may help them to sustain their tenancy long term and prevent eviction. They were advised that there would be an expectation that they would engage with the process throughout.

Due to the level of support they needed they were referred to the City Council's Tenancy Sustainment Service (TSS) and the co-ordinator later arranged the initial assessment visit with the TSS worker and a support plan, agreed by both clients, was put in place. The plan included:

a. To start reducing the debts.
b. Rehab as a couple
c. Renew contact with family members
d. Sort out the repair issues with the property – damp/plumbing/electrics
e. Sort out their benefits - PIP / DLA applications
f. Apply for a bus pass
g. Source funding for materials for hobby
h. Consider other avenues of on-going support

Unfortunately, whilst they accepted visits and were very articulate about what they wanted, there was an element of disguised compliance in order to hold on to their flat rather than making any significant changes in their lifestyle or behaviour. They would agree to a home visit but would cancel at the door, claiming to be unwell. On other occasions, they would accept visits, discuss what was needed, accept anything that would be to their advantage and make excuses for anything else. For example, the flat had areas of damp, the couple felt let down by the Council as other flats had been treated but not theirs and impacted on how it made them feel about themselves. They also needed various adaptations to the bathroom and again said they felt they had been treated unfairly and argued that this was impacted on how the partner was managing. They agreed to attend Inclusion; however every appointment was met with an excuse for not being able to attend or that they were unhappy with the service provided.

It was hoped that in having regular contact with the TSS worker who could build trust and being involved in the pilot might motivate them to take small steps forward. There was potential for a move if it was felt that they were engaging with support and working with the ASB officer to manage the behaviour of others. Any perceived obstacles (benefits, repairs, etc) were removed in order to ensure they could move forward with the support plan and their landlord, City Homes agreed to allowing time for the support to bed in rather than rush to court.

In spite of having their own accommodation and an intensive support service they were unable to make any changes to their lifestyle, continued to be involved in ASB and criminality. Throughout the process they did not accept responsibility for any of their difficulties, but believed it due to failings by the authorities, Police, NHS, Benefits,

Inclusion, etc. in spite of these issues being addressed as part of the pilot. Every effort was made to support them to sustain their accommodation yet it failed. They are now street homeless and in spite of a sustained effort to engage them with support they have continued to refuse what is on offer, putting forward a myriad of excuses rather than accepting any responsibility.

2. Case Study 2 – Single male in high support hostel accommodation

The client had lost previous accommodation due to behaviour and was struggling to manage life in the hostel. He was diagnosed with schizophrenia, had borderline learning disabilities and was an intravenous drug user. He was estranged from family. He was referred to the pilot by his hostel key worker. The reason for referral was given as "*to help with future tenancies.*" The section about long term goals and what was needed to achieve the goals was left blank. In addition to his key worker, the client was also supported by Inclusion, a CPN and a social worker. The co-ordinator agreed to visit the key worker and the client to go through the pilot and what it would entail and explaining that it was not a route to accommodation but about looking at what makes it difficult for someone to move on and to ascertain from the client what they need to move forward and to eventually sustain their own accommodation.

Pilot meetings were arranged to include all the support agencies involved, however this was not always feasible due to schedules. Nevertheless the co-ordinator and keyworker would always be present.

In this case the client was not able to articulate his views clearly and seemed to have little insight into his support needs. Although he attended almost every meeting, on occasions he was restless and would want to leave the meetings quickly. He was not able to come up with his own ideas, instead he would agree to whatever was suggested. It was therefore difficult to see what the value was for him in attending the meetings.

Initially it was agreed that that in the future suitable accommodation might consist of low support shared accommodation. His depot injections would be managed by the mental

health team as part of his care package, which would also include support with training, keeping appointments and basic life skills.

The aim was for him to eventually register with Homelink, and move into his own accommodation with a care package in place. Funding was available for mental health support, which would have consisted of 3 visits a week.

His mental health support worker tried to engage him in positive activities, such as going to the gym, however he didn't engage with this. We discussed long term goals, but without the clients input it was difficult to put anything in place. He was not ready to reduce his drug use. When asked how he spent his days, he said he walked about. He was monosyllabic, appeared disinterested and made little eye contact; whether this could be attributed to his learning difficulty, drug use or mental health diagnosis was unclear.

He did attend nearly all the meetings; however whether this could be seen as 'engaging' is debateable. The meetings were always held at the hostel where he lived and at a time convenient to him. He didn't need to go far and very little was required of him at the meetings. The co-ordinator, not an expert on mental health or support was often looked to for the answers. It was also difficult to grasp what constitutes 'support' when the client has no insight to what they need or want.

He gradually started to withdraw from the pilot. During one meeting he said he didn't want a support plan, "it was all rubbish". When asked what he would do if he lost his room, he said he didn't care he would "live in a box". It became very difficult to have any meaningful sessions with him and his behaviour within the hostel deteriorated.

His supported accommodation was at risk due to his behaviour that was considered a health and safety risk to others. He was given a 7 day notice to leave the accommodation. Social Care would not consider him for supported accommodation and his options were limited. The pilot did not come with any promise of a magic wand to cut through bureaucracy and get someone accommodated. Unfortunately, thresholds for supported accommodation are high and the options are very limited for individuals with dual diagnosis, who are difficult to engage and problematic.

3. Case Study 3 -. Single female high support hostel accommodation

Client was referred by her accommodation key worker. She was in the hostel following a managed move from her tenancy where she had been financially exploited and the property had been taken over. She was considered to be vulnerable and had a long history of being taken advantage of by others. Her key worker, however was under the impression she had been evicted from her tenancy and was now working with her to get her back on Homelink and into her own accommodation.

She had a diagnosed mental health condition managed by a depot injection, had other health conditions and was a drinker and drug user. She was supported by a CPN, Mind, Inclusion and her accommodation support worker. The reasons for referral were listed as "*for help to get a new tenancy and help to keep my property*." Her long term goals were "*to be happy in my home"* The next question "what do you feel you need to achieve these goals was answered "*to have my own home."* Completing the referral offered the opportunity for the support worker and the client to discuss how they might go from hostel accommodation to having and sustaining their own accommodation, what would they need to put into place. This wasn't reflected in the referral form. For example there was no mention of reducing her drug intake , managing relationships, or participating in positive activities.

The initial meeting involved the client, the pilot coordinator and the key worker. As with each of the referrals it was necessary to explain that participating in the pilot was not a fast track to independent accommodation and there would be an expectation that she engaged with the process and managed her current accommodation. She wasn't planning to reduce her drug intake yet, liked being busy and the discussion centred on getting her involved in positive activities and what additional support she needed.

She was stilling associating with problematic individuals and there were concerns that she was giving them money. It was therefore agreed that the keyworker would focus on strategies to help her manage her money and help her access positive activities.

She was similar to the single male referred to in case study 2. She was very immature and appeared to have little insight into the difficulties that had led her to losing her flat.

She engaged well with the process and attended the meetings, was able reduce her arrears and attend positive activities. However she did not reduce her drug or alcohol, her mental health deteriorated whilst she was involved with the pilot and she was sectioned.

SUMMARY

As with all the case studies the hostels are under pressure to move people on and their main objective is getting someone to the stage where they can move out of the hostel in into their own flat. Obstacles such as rent arrears often slow the process down, and whilst someone is using they are less likely to be paying of their arrears, which in turn prevents them moving on.

Moving people into their own accommodation when they are barely managing their hostel accommodation is arguable setting them up to fail, particularly when a care package for the most vulnerable might only consist of twice weekly visits.

All the case studies above were similar in that the clients were estranged from family, had no informal support connections, which in turn made them vulnerable to exploitation from those purporting to be friends and offering company.

Furthermore it was difficult to get buy in from the clients once they knew that participating in the pilot was not a fast track into their own accommodation. There was no real incentive for them to take part. The one referral that was a success had reached a point in his life where he was ready for change and has successfully transitioned from hostel to his own tenancy. All the others referred, although arguably in the middle group made very little progress.