Filling the Gaps
(1988-1989)

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FILLING THE GAPS

An account of

the development of the

Elmore Community Support Team

April 1988 - February 1989

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CONTENTS

Filling the gaps.....1

Table 1 - Referrals Jan.-Feb. 1989.....14

Table 2 - Number of referrals from different agencies 14

Table 3 - Number of agencies involved with persons referred....15

Table 4 - Agencies known to have current/continuing involvement with persons referred.....16

Table 5 - Acceptance and non-acceptance of referrals.....17

Notes.....18

Appendix 1 - Objectives of the Elmore Community Support Team...19

Appendix 2 - Placements undertaken by Community Support Team members as part of initial induction.....20

Appendix 3 - Guidelines for agencies referring to the team.....21

Appendix 4 - Members of the Elmore Committee, the Management Committee and the Community Support Team.....22

FILLING THE GAPS

An account of the development of the Elmore Community Support Team April 1988-February 1989 [1]

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1. INTRODUCTION

The Elmore Community Support Team is a new and experimental venture in the care of persons

> who, due to their bizarre and/or disruptive behaviour, are seen to be misplaced by those currently working with them, and
>
> for whom the statutory sector finds difficulty in accepting responsibility because they need a wide variety of support and provision which cannot be met by one service alone. [2]

Such people have come to be known locally as 'difficult to place'. Typically they experience multiple problems, revolving around homelessness, mental illness or personality disorder, and aggressive, disruptive or bizarre behaviours some of which may come to be defined as offences. Such problems can compound each other; for example, the behaviours that stem from mental illness or personality disorder may lead to homelessness but this in turn can produce further bizarre or aggressive behaviour. In addition, these persons may also have such problems as abuse of drugs or alcohol.

Such persons often develop a lifestyle which revolves around several agencies - a common pattern might be sleeping at a hostel or night shelter, spending the daytime in a day centre, and receiving periodic psychiatric attention. Typically, however, workers in these agencies do not feel that the person is receiving appropriate or sufficient care, whilst at the same time their tolerance may be stretched or broken by the individual's behaviour. But because each of the problems and behaviours is usually the province of a separate group of professionals (or, frequently, voluntary bodies), it is very difficult to co-ordinate and provide the range of support that such people need and would be prepared to accept. This is so despite elaborate referral and co-ordination mechanisms.

2. THE BEGINNINGS OF THE TEAM

The above points are more fully documented in the Elmore Committee's 1987 report, *Support for difficult to place people in Oxford*, which in a 1986 survey identified 138 'difficult to place' people in Oxford. That report proposed the establishment of a team of workers who would operate

a small 'respite centre' to which such people would be able to go for short periods when the tolerance of other agencies had been exhausted. In addition the workers would support the staff of other agencies in caring for these clients on a longer-term basis. The work of the respite centre staff would be overseen by an inter-agency panel.

Discussions after the publication of the 1987 report led to the conclusion that such a centre either would be unmanageable due to the level of tolerance required to deal with people in crisis, or would only be able to house the 'better bets'. In addition, financing accommodation which would by design only be used on an occasional basis seemed inordinately expensive.

The Elmore Committee's work on the 'difficult to place' was, on a day-to-day level, organised through a 'DTP Sub-Committee'. Although the Sub-Committee made some attempts to identify suitable premises and to find funding, it also considered an alternative plan in which a team of workers would be established whose role it would be to support both 'difficult' individuals and the staff caring for them in other agencies, but without the provision of any unit of accommodation. No specific conclusions were reached. At this juncture, funding appeared from a wholly unexpected source. In April 1988 the Department of Health and Social Security (as it then was) offered the Elmore Committee the sum of £186,000 over two years for a pilot project. The grant was part of the 'Retail Price Index error' payment to charities, in which an error in the payment of Supplementary Benefits and the impossibility of paying very small sums to a large number of recipients had prompted the Department to disburse an amount equivalent to the RPI error among a number of voluntary organisations.

In May 1988 the Sub-Committee refined its proposal for a team. In essence it would comprise a co-ordinator, three support workers, one of whom would be a psychiatric nurse, and an administrator. Provision was also made for a half-time research worker. The idea of a 'respite centre' was dropped. The main objectives of the team were to support 'difficult to place' persons and to guide them back to the existing network of provision where they had slipped through it; to provide follow-on support to individuals and to agencies in order to promote the chances of future stability; and to encourage, strengthen and extend inter-agency liaison to help the 'difficult to place' - which necessarily meant securing further attention for the client group at senior managerial levels. These objectives and others are stated more fully in Appendix 1, which presents extracts from the project proposal.

In June 1988 further discussions with the DHSS took place and practical details of funding were arranged. The Sub-Committee was disappointed when it became clear that, in terms of the two years of funding, the clock was already ticking. The grant was to run until March 1990. This made speed imperative. However, plans for recruitment were already under way. The Sub-Committee took the view that a pilot project of this nature, in essentially unknown territory, required a co-ordinator with extensive local knowledge, proven abilities in dealing with the kinds of people likely to become clients and in dealing at senior managerial levels, and who would come with a pre-existing credibility so far as other agencies were concerned. It decided to 'head-hunt' one of the very few people who successfully met these criteria. At the same time,

office space for the project was offered by the Oxfordshire Probation Service.

On 1 September 1988, the project comprised a co-ordinator, an office and a telephone. In that month and the next, plans were laid for the recruitment of further staff, negotiations took place with the Health Authority over the secondment of a community psychiatric nurse (ultimately this did not take the form of a secondment but of the release of a CPN on a recharge basis [3]), and the shape of the project was mapped out in further detail.

In early November all the staff except the CPN came into post. Of the two support workers, one was also 'head-hunted' from the local Night Shelter where she had extensive experience with the projected client group. The other, with qualifications in both nursing and social work, was appointed following an advertisement. The administrator had previously worked for a large charitable organisation. The CPN joined the team on 1 February 1989, although he had been able to spend some time with team members prior to this.

Meanwhile, the co-ordinator and the Sub-Committee developed a formal structure to which the team would be accountable. The Elmore Committee was expanded to include representatives from the Social Services Department, the City Housing Department, the local psychiatric services, and a prominent GP who had links with several local voluntary oganisations. This Committee, meeting three times per year, was to be in overall charge of the project. Most routine matters would, however, be handled by a project sub-committee, comprising the members of the original 'DTP Sub-Committee' together with several new members, including a principal psychiatric social worker, the special projects co-ordinator from a local housing association, and the project co-ordinator himself. This sub-committee would meet about every six weeks to review the project.

3. BUILDING THE TEAM: FIRST THOUGHTS

When the team came together for the first time in November 1988 neither it nor the co-ordinator nor the researcher had many clear ideas about how it would function. There were no models to build on. Team discussions resulted in agreement on the following nine points, which gave some structure to the working of the team.

1. 'Difficult to place' was not a good description of the client group. It tended to leave the impression that the team was supposed to find a 'place', i.e. accommodation, for clients, whereas in reality it would be looking to work with clients and workers in other agencies to put together 'packages' of care and support in which accommodation might be only a minor part. Counselling, daycare and so forth might ultimately prove more important in working with clients.

2. Referrals would come from agencies and organisations. Individuals would not be able to refer themselves to the team. There would be no tight definitions of the client group, so that the team would be able to respond to whatever made the clients 'difficult' in the eyes of the agencies dealing with them. There would be no referral form to be filled out by a referring agency, so as to keep bureaucracy to a minimum. Referrals by letter, by phone, by personal contact or by carrier pigeon would all be equally acceptable. A 'contact sheet' to be filled in by the team member receiving the details would take the place of a referral form.

3. As a qualification to this open policy, however, where it appeared that another agency had a responsibility towards a client, that avenue should be tried by the referring agency before the team became too closely involved. This was intended not only to place responsibility where it lay but also to avoid treading on the toes of other agencies which might properly resent their roles or clients being 'poached'. The team would be working with other agencies to progress the situation sufficiently for the latter to take on the provision of care.

4. The team would seek to ensure that clients knew, in broad terms, that they had been referred to the team and also to ensure that they did not object to the team working on their behalf. To date there has only been one instance of a client refusing help from the team when it was offered.

5. The size of the team made a broadly 9-5 working day inevitable. There were not enough workers to make weekend and night work possible and its necessity was doubtful. It was thought that 'crisis intervention' work would play a part; the team recognised it might be able to 'cool down' incidents but that its role was not to duplicate that of other agencies and its main thrust would be to work for longer-term solutions. To cover emergency referrals an 'on-call' system was instituted.

6. An 'allocated caseload' system would operate, with each worker taking a group of clients from across the range of agencies and working with them. This would also be true for the CPN, who would not be given exclusively 'psychiatric' clients. This followed the observation in the 1987 report that the skills of a CPN could be used in a wide range of situations while other workers without psychiatric training could sometimes discover wholly unconventional but effective means of support (in the 1987 report the example was given of a person who remained stable provided he could visit a particular voluntary sector worker each week and insult him).

7. It was thought that team members could hardly introduce themselves as having become involved because the client had been 'difficult'. The co-ordinator's experience suggested that the best approach would probably be to avoid labelling oneself as a 'worker', but simply to get on first-name terms as soon as possible, to be interested in the client and to allow him or her to forget or avoid the issue of being a client. It was suspected that at least some of the problems experienced by workers may relate to the phenomenon

that, in the client's world, clients have needs but nothing to offer, while workers have a degree of power and something to offer but require that the client fits into a pigeon-hole. The likely clients of the team would be people so damaged that they could no longer fit themselves into the pigeon-holes necessary in order to obtain support. Yet they might be able to cope with more personal, two-way relationships in which the client has the opportunity to offer something.

8. It followed from the above that at least part of the team's professionalism would lie in preventing clients from seeing them as 'professionals with a service to offer'. The kinds of services that they could offer would very likely rely upon clients not seeing themselves as clients or the workers as 'professionals'.

9. Finally, it followed from all the above that the workers would necessarily have to live with a great degree of uncertainty. Their role would not be clearly defined except through the particular circumstances of each case. There would be no set of procedures or services applicable to any particular groups of clients. Similarly, workers in other agencies would have no clear definition of the team's role at the outset but would have to learn it through experience.

4. BUILDING THE TEAM: THE PRACTICALITIES

Two aspects of the setting up of the team gave its members an opportunity to reduce some of the uncertainties mentioned above.

First, members went to a range of agencies to undertake placements ranging from half a day to several days. They were able to explain the objectives of the team, to become known as personalities and to know the personalities and procedures involved in other agencies (for a list of placements see Appendix 2). In addition, they were able to swap experiences and insights. For example, it was noted that in one voluntary sector hostel, a surprising amount of the support of residents came not from the support workers but from the cleaners, who were then identified as important people to meet and know. Team members also began attending various inter-agency meetings taking place regularly in Oxford, which also enabled them to explain their objectives and to know, and be known on, the 'network' of agencies.

Second, three clients were 'hand-picked' in November and December and the support workers were able, as the co-ordinator put it, to 'walk through' the process of working with them and to see what it would feel like to work with clients. This was an interesting experience for all concerned. With one client, it involved no more than intervening on his behalf with the electricity board in order to ensure that he would not be cut off. This enabled him to remain stable in a flat that had been found for him by another agency. In the case of another, the worker found herself:

1. - negotiating with the City Council to help him keep a flat he was in danger of being evicted from

2. - discussing with the psychiatric services whether his medication was still appropriate - she had discovered that, over a period of time, the medication had begun to create spells of lassitude which in part explained his inability to manage time and to manage cleanliness. In the event, his medication was changed and some of the problems were eliminated

3. - trying to help the client differentiate between those friends who abused his hospitality and those who genuinely offered friendship

4. - trying to improve his sense of time and punctuality by setting specific times for meetings and refusing to see him without prior arrangement or if he was more than about 15 minutes late

5. - helping him to find voluntary work of a suitable nature

6. - setting up a regular meeting of the caretaker involved with the client's flat, the Council Manager of the block and herself; principally to provide support for those surrounding the client

7. - offering pungent advice on his personal cleanliness

The discussions, placements, meetings and 'practice runs' with clients helped to give some content to the hitherto rather abstract objectives.

In the background, three other processes are worthy of mention:

First, the co-ordinator felt it was important to ensure that his previous employer (the Luther Street Clinic, a surgery for homeless people) and that of one of the support workers (who had been head-hunted from the Night Shelter) were not inconvenienced by their departure. It would have been ironic if a team intended to promote inter-agency co-operation started life by alienating or impeding the agencies it was intended to support.

Second, while it was recognised from the outset that other agencies would want, as a point of reference, some written guidelines and descriptions of the project's work, the experience of the team members during their 'placements' was that this would need to be done sooner rather than later. Other agencies were by no means quick to grasp the objectives or the likely methods of operation of the team. In the event, these guidelines (reproduced as Appendix 3) were produced and circulated early in January 1989.

Third, early discussions recognised that much of the team's work would relate to offenders and that it could have an influence on the way in which, for example, magistrates viewed the viability of non-custodial measures for 'difficult to place' offenders. It was also pointed out to the team both by the chairman of the new Management Committee and by probation officers that magistrates needed to be informed, in general if not in individual cases, that a new service was being provided to some of those appearing before the courts. They also needed to be aware that the team was working in co-operation with the Probation Service. The kinds of work envisaged by probation officers included, for example:

- making efforts to secure accommodation, daycare, and so forth in the event of a non-custodial sentence. Often probation officers do not have the time to 'stitch together' packages of care that can be essential adjuncts to non-custodial sentences and may make the difference between a non-custodial sentence and a custodial one. That another body could investigate such possibilities and report back in time for them to be presented to the court was seen as a significant step forward.

- having a support worker available to support a client into hostel accommodation immediately after the hearing if a non-custodial sentence were to be passed. This kind of work often cannot be undertaken by probation officers who have other commitments in court following the hearing, and yet there was an awareness that support in the first few hours of a non-custodial sentence could be a significant help in keeping the client out of trouble.

The team announced itself 'open for business' on 3 January 1989, some eight months after funding was secured; four months after the appointment of the co-ordinator; two months after the support workers were appointed; and one month before the CPN could join the team full-time. It felt, to all concerned, as though the whole project had been devised and implemented in a very short timescale given the distance that had been travelled in that time.

5. UP AND RUNNING: THE FIRST TWO MONTHS

A commentary on the first two months of operation cannot be regarded as a definitive statement on the team's work. New problems are constantly arising and being addressed; new opportunitites being discovered and exploited; practices are mutating. What follows is an account of what has been done, illustrates what can be done, and provides some markers for future evaluation [4].

In January 1989, 23 persons were referred to the team; in February, 19 persons. At the time of writing (March 1989) the team is working with 20 persons on a face-to-face basis and in addition acting to co-ordinate work on, or supporting others in dealing with, a further 16. These figures are not particularly significant since they reflect an agreement with various services to 'phase in' clients rather than refer all appropriate clients on day one of the project. Moreover, they do not accurately reflect workloads, partly due to the different kinds of interventions undertaken by the team and partly because some of the early clients are, at the time of writing, still receiving substantial direct team support. The team's support workers felt in the first two months that they were being under-utilised; by mid-March this had ceased to be the case, though as yet there are no clear indications as to what an appropriate number of active cases might be. The pattern of work tends to revolve around several new referrals per week to investigate and discuss, at least one meeting per week with each of the 'active' cases, work to initiate or co-ordinate multi-agency working, and a good deal of 'cultivation' - attendance at meetings, visits to other institutions and discussions with staff, and telephone conversations intended either to further 'active' cases or to keep track of those on whom a 'watching brief' is being kept (this is explained further below).

At the same time, emergencies occur which derail planned daily schedules, as when a worker was called to help calm a client who had launched himself through the window of a day centre, apparently in an attempt to persuade staff there that he was a danger to himself and should be admitted to a psychiatric hospital. When taken to hospital for stitches and a psychiatric assessment he jumped through another window there; he was judged simply to be attention-seeking and discharged within 48 hours.

An age and sex breakdown of the referrals is given in Table 1. One peculiarity is that over one quarter (29%) are female - double the proportion of females found in the 1986 survey (13%). The absolute numbers are very small and open to wide variance, but it is commonly held, in the voluntary sector at least, that an increasing number of women seem now to be users of hostels and emergency night shelters. The reasons for this are not clear.

Ideas of what constituted 'referral' and what the 'acceptance' or 'rejection' of a referral meant quickly departed from expectations. Referrals have so far come from: single agencies, two agencies jointly, an inter-agency meeting, and a case conference. Some of these came as requests for advice or simply as discussions to explore ways forward; some as requests to undertake specific tasks; some as requests to look at the situation and for the team to make referrals to other agencies as necessary. The team has also identified 'half-referrals', situations in which an agency phones with a suggestion that an individual might be in need of attention but would prefer the team to approach the individual direct rather than via that agency. This shades into a 'consultancy' role (in which the team is invited to look at identifying ways forward) and a 'catalytic' role (in which the team takes up the case primarily to encourage others to reappraise it). Referrals have also come from sources that were not anticipated when the project was set up. Some have come from the accident and emergency unit of the local hospital or from hospital social workers, following problems in discharging patients. Several have come from the police, where individuals have been found in a condition suggesting that they may be a danger to themselves. The provenance of referrals, including 'half-referrals', is given in Table 2; a breakdown of the agencies known to be involved with those referred (irrespective of whether or not they were the referring agency) is presented in Tables 3 and 4.

Broadly speaking, the outcome of referrals can be categorised into four types (see Table 5 for a numerical breakdown):

1. a decision that the person is inappropriate as a client for the team. Such decisions have to date always been made jointly with the referring agency following extensive discussions and, if possible, advice about other possible routes. This is so because the referral structure and the definitions of 'difficult to place' have been deliberately left as open as possible in order not to inadvertently exclude individuals from the definition.

2. a suggestion that the referring agency try another line of action, usually because the client appears to be the responsibility of another agency.

3. a decision that it is not possible, given the individual's circumstances, to work with them at that time. This may be for various reasons; for example, because the individual refuses help, or because their situation is so confused that no avenues of progress are apparent. In such cases the team operates a 'watching brief', keeping track of the individual so that the position can be reviewed if his or her circumstances change.

4. an aceptance of the individual onto the caseload either for specific purposes or on a more general and long-term basis. In the more long-term cases the team does not neccessarily work directly with the individual, but may instead offer to work with others who are giving support to the person and help them through crises when they occur.

There have to date been no referrals in which non-acceptance has taken place without discussion with the referring agency and, if possible, identification of alternative lines of action; and few referrals about which no action has been taken even if that action has only been to refer the case on to another agency and/or to keep track of what is happening to the client.

In keeping with early expectations, there has been only a small handful of 'emergency' referrals in which agencies were asking for immediate action to be taken by the team. In general, the circumstances in which cases have been 'taken on' have been:

- a perception that an individual's behaviour and quality of life have both deteriorated over a period; one example, taken from the referral sheets completed by workers, concerns an individual who floated betwen Simon House and the Night Shelter. The reason for referral was stated as 'He winds people up. He is more often in the Night Shelter than previously. Quality of life deteriorating.' Or

- that an agency wishes to hand on the case (or accept a case from another agency) but certain problems need to be addressed first. One example is an individual at that time in the Night Shelter: 'A Simon House resident of many years, psychiatric history, not on medication, but getting more aggressive. Barred for one month from Simon House ... they will take him back if he goes on medication.' Or

- an agency is attempting to help an individual but perceives itself as having run out of lines of approach. An example is: 'Concerned he needs extra support through three or four bad patches a year. Recently he gave up a (housing association) flat to go back to a poor-quality bedsit.'

This last requires a little more explanation. The individual involved had a long psychiatric history though has not been an in-patient for some years, and suffers bouts of disruptive and sometimes aggressive behaviour in daycare. A fourth case is unique, though it actually symbolises the intentions of the project: the person concerned was aged 24, had a history of homelessness and drug use, has recently been allocated a council flat, but seemed to be spending les and less time there and gradually becoming less and less stable. The referral form

notes: 'She is involved in solvent abuse. There is a threat of eviction. She is worried too many agencies are now involved and are working against each other.'

The practical support offered to clients following acceptance of a referral has been straightforward, though diverse. It has usually consisted of trying to arrange accommodation or daycare, sorting out financial arrangements, asking psychiatrists to reconsider current medication, and simply keeping in contact with the individual and providing a friendly presence. As the co-ordinator puts it, by the time the client is referred to the team a great deal of spadework has usually already been done by other agencies, and it is rare to be able to suggest an option that has been completely overlooked by workers in other agencies or to provide a wholly new solution to a problem. In this sense the team does not possess a magic wand that can improve clients' quality of life at a stroke.

The other and arguably more important part of the team's work, however, lies in its working with other agencies to try to find ways of helping them to help the clients. There are three aspects to this, all of them 'discovered' in the first few weeks of operation.

First, a referral to the team may in some ways relieve psychological pressure but does not take day-to-day client management pressures away from the referring agency. It results in extensive discussion without any immediate prospect of the presenting problems being solved. And almost by definfition it entails looking more closely at what has gone wrong and accepting what is, to some degree, an inability to provide for client needs. Much of the worker's time is taken up with what the co-ordinator has described as 'absorbing' and as 'working with' other workers' feelings of failure. At the same time, the re-digging of old ground can and has resulted in the re-evaluation of options which had been too quickly dismissed.

Second, the team seems to have developed their role as 'network brokers', to use the phrase coined by the co-ordinator. This seems to have developed spontaneously, though it seems also to offer considerable potential. In many of the cases taken on so far, the team has acted in the first instance simply as a conduit for information. Agencies which were not aware of each others' roles in an individual's situation have been put in contact with each other and kept aware of what the others are doing. They have also been made more aware of the individual's total situation rather than simply that part of it which touches on their own mandate or function. In consequence they have been able to make more informed decisions about how to deal with that part of the person's life in which they are involved. This role requires delicate management of confidential or at least non-public information. In one case, for example, the City Housing Department was considering evicting a particular individual but did not know that the person was on a probation order which could be prejudiced as a consequence of homelessness, whilst the Probation Service did not know about the forthcoming eviction. This situation clearly arose because the Probation Service, quite properly, does not inform all and sundry of probation orders, and the Housing Department sees itself primarily as a landlord which does not need to know the intimate details of tenants' lives. By intimating to each agency that the other was making decisions about the

individual, the team averted a potential problem. No further information was given to either, so that each could decide for itself what it should tell the other about its own involvement.

Third, this approach meshes with the redefinition of a traditional technique of dealing with clients - the case conference. The team has now held several case conferences on clients. They are underpinned by the fact that while the team is not neccessarily the most appropriate agency to work with a client, it does have the resources to do much of what other agencies - including statutory agencies - would do for clients on a day-to-day basis. In consequence, the structures of care that can be developed are very flexible. When other agencies have worked out what they can and cannot do for a client, the team is able to invest its own resources in plugging the remaining gaps.

To conclude this section, two anecdotes will give some flavour to the rather abstract account presented so far.

In one case, an individual regarded by several agencies as 'difficult to place' appeared in court. One of the magistrates hearing the case was the chairman of the Elmore Committee. The probation officer's social enquiry report proposed that a non-custodial sentence be considered, given that hostel accommodation and a package of support had been arranged for the client in such an event. The court decided on a non-custodial sentence in the light of this. The chairman of the Elmore Committe discovered - later that day - that the package of support referred to by the probation officer had arisen out of discussions, immediately prior to the hearing, with the Elmore Team co-ordinator who had then been able to secure the offer of a hostel place on the basis that both the team and the probation officer would be able to support the individual in accommodation.

In a second and rather different instance, workers in the Night Cellar (which provides emergency accommodation for young people) had difficulty in managing a 17-year-old female (who had been homeless since age 14) with a history of drug use. In the event the team did not immediately take on the case but encouraged the Night Cellar to contact Social Services direct in order to start procedures moving. The girl was taken on as a Social Services client and given bed and breakfast accommodation - not ideal, but it resolved the immediate problem and gave time for a more considered appraisal of the girl's situation. The social worker proposed first to reinvolve the girl's family, but also began to suspect that she suffered from epilepsy and also from anorexia and was able to involve the relevant services. At this point the team became involved again both in putting her in contact with a drugs counsellor and in trying to find more permanent accommodation. With the Night Cellar now prepared to act as a 'backstop' should her behaviour be destructive, and with the offer of support from the team, Windmill House (a combined development of hostel and bedsits for young adults) was approached about a possible place. Previously the girl had been refused twice due to her drug use and the lack of support, but she has now been reassessed and offered a place.

6. FIRST REACTIONS

It is clearly too early for there to be any comprehensive picture of how the team has been received by other agencies. Two brief comments are possible, however.

Relations with other agencies are not neccessarily easy, nor was it ever expected that they would be. After all, the purpose of the team is to persuade other agencies to continue working with people who they might otherwise ban or bar, and to take on clients who in the past they would probably have refused. At the time of writing, one client placed in a hostel has been disrupting daily routines by setting off the fire alarms, and this is a matter being discussed by the team and the hostel manager. However, it seems from the limited experience of such problems to date that the fact that the team does offer support to both clients and other workers, and will discuss problems of this nature and seek to find solutions, has minimized tensions.

On the other hand, at least one set of workers seem very happy at the emergence of the team. Staff at the Probation Day Centre have indicated that they feel much less isolated in taking on the daycare of a very difficult group of individuals. This is so despite the small number of clients actually referred from the centre and the even smaller number taken onto the team's caseload. This feedback is particularly gratifying sine the workers' view is shared by the Senior Probation Officer.

A feature of the team's work which has been commented on favourably by several agencies and which is now regarded as an important component of the team's approach is that even where referrals are not taken on, 'progress-chasing' calls are made back as a matter of course to ensure that nothing untoward occurred and that no further action by the team is needed. This is apparently such a departure from other agencies' normal practice that it has become a hallmark of the team's style of work. Several workers in other agencies have individually commented that they have found it a refreshingly positive attitude.

7. FOR THE FUTURE

Two areas can be marked out as potential problems for the future. The first is that of indicators of 'success' and 'failure'; the second that of confidentiality.

The team is working with a group of people for whom 'success' in any form is rare; they are by definition those whom other agencies have had most difficulty in supporting. One-off successes are possible. Obtaining accommodation or daycare for an individual, persuading him or her to take a bath, or sorting out DSS claims, are all successes of a kind, though usually transitory - they often have to be tackled again within a short space of time. Any more significant markers of success will only be discovered in the longer term, when for example it becomes apparent that an individual has been stable in one package of care for a period of months rather than simply days or weeks. It is recognised within the team that it is difficult in the short term to be able to have a sense of 'how well it is doing' - yet the lack of such measures leads at times to uncertainty and anxiety. One possibility to be explored further is the idea of notional targets for success, set in each individual case. For example, if an individual has repeated bouts of disruptive behaviour

which in the past have taken place every two or three weeks, it could be counted a success if the intervals between disruptive episodes lengthened to four or five weeks. In one way, this approach to looking at success underlines the need for a continuing monitoring of clients' progress, so that stability of this kind can be measured; but it also warns against counting success too easily - otherwise some element of every case could be counted successful and then be taken to stand for the whole case. It must also be recognised that the unpredictability of many clients means that 'success' may be an unintended rather than intended effect of actions taken.

Second, it is implicit in the description above of the 'network broking' role that sooner or later judgements will need to be made about how far confidences can be kept or shared. In principle, such issues can be dealt with through the management structure, since the Elmore Committee has representatives from all the statutory agencies involved in the problem. As yet no such problems have arisen and so the mechanism is untried. Equally, it is as yet unclear how the 'network broking' might lead to a blurring of the boundaries between agencies with different mandates. It is clear that putting, for example, the City Housing Department and the Probation Service in contact with each other can prevent an eviction with consequences for a probation order. Yet it is by no means clear whether, for example, it might ultimately result in the Housing Department (or any other accomodation resource) being co-opted into the active management of an individual's lifestyle rather than acting simply as a landlord.

Although it is possible to identify areas that may prove problematic for the future, a note of optimism is an appropriate end for this report. The team was set up quickly and in a way that elicited promises of co-operation from other agencies. Referrals have been made, and the processes for dealing with them - even where they are not accepted - appear to be regarded by others as helpful. This applies in particular to the cardinal rules of discussing every referral with the other agencies and if possible offering advice rather than flat non-acceptance, and of making calls back to check the client's progress. Where cases have been taken on, the team's interventions seem to have been accepted as constructive. They have, quite clearly, enabled other agencies to re-evaluate what they can do with and for 'difficult' clients. What should constitute a 'full caseload' and how success with clients can be evaluated remain to be seen, and the team will need to weather some uncertainty in these directions for some time to come. Perhaps the best summary of the current position is that it promises to be an extraordinarily helpful addition to existing provision and that as yet the team has not come up against any clear limits to the range of benefits it can bring, both for clients and for the other agencies working with them.

TABLE 1: REFERRALS JANUARY-FEBRUARY 1989

Age	Male	Female	Total
20 and under	1	1	2
21-30	6	6	12
31-40	6	2	8
41-50	7	0	7
51-60	3	3	6
61 and over	1	0	1
Age unknown	6	0	6
Total	30	12	42

TABLE 2: NUMBER OF REFERRALS FROM DIFFERENT AGENCIES

Agency	Number of referrals
Police	3
Probation (all teams + Day Centre)	11 (including 1 from case conference)
Social Services (city, mental health, mental handicap teams and hospital social workers)	7
Psychiatric wards	3
Specialist (brain-damage) unit	2
Night Shelter	4 (not including 1 joint with Simon House)
Night Cellar	1
Simon House	5 (including 1 joint with Night Shelter)
Church Housing Hostel	1
MIND (daycare and hostel facilities)	3
Richmond Fellowship	1
Local housing association	1
TOTAL	42

TABLE 3: NUMBERS OF AGENCIES INVOLVED WITH PERSONS REFERRED

Number of agencies known to be involved with client	Number of referred persons
1	5
2	12
3	13
4	9
5	0
6	2
not known	1

Total number of referred persons = 42

Total number of mentions of agencies = 117

TABLE 4: AGENCIES KNOWN TO HAVE CURRENT/CONTINUING INVOLVEMENT WITH PERSONS REFERRED - NUMBER OF MENTIONS EACH AGENCY RECEIVED

Agency	Number of referred persons with whom involved
Police	4 (n.b. excludes contacts for offending)
Probation (all teams + Day Centre)	17
Social Services (all teams)	10
hospital social worker	5
Medical/psychiatric units:	
psychiatric wards/units	12
detox unit	2
Barnes Unit [1]	4
Luther St. Clinic [2]	8
GP	3
other medical	5
Church Housing	7
Night Shelter	15
Night Cellar	2
Simon House	8
Windmill House [3]	1
MIND (accommodation/daycare)	4
Richmond Fellowship	2
Local housing association	1
City Housing Dept.	2
DSS	1
Other	4
TOTAL	117

[1] emergency unit for self-injury (e.g. overdose)
[2] health clinic for homeless persons
[3] hostel and bedsit accommodation for young adults

TABLE 5: ACCEPTANCE AND NON-ACCEPTANCE OF REFERRALS

Agency referring	Referral inappropriate*	Half-referral	Consultancy/ catalyst role	Accepted onto caseload	TOTAL REFERRALS
Police	-	-	2	1	3
Probation					
day centre/ city team	1	-	2	7	10 [1]
hostel	-	-	-	1	1
Social Services**	-	-	1	1	2
hosp soc wrkrs	-	1	4	-	5
Psychiatric wards	1	-	1	1	3
Brain damage ward	2	-	-	-	2
Night Shelter	-	1	-	3	4 [2]
Night Cellar	-	-	-	1	1
Simon House	1	-	2	2	5 [3]
Church Housing	-	-	-	1	1
MIND	1	1	-	1	3
Richmond Fellowship	-	-	1	-	1
Local housing association	-	-	-	1	1
TOTAL	6	3	13	20	42

* column also includes 1 person who died around the time of referral and 1 seen as inappropriate
** City, mental health and mental handicap teams
[1] including 1 from a case conference
[2] not including 1 joint with Simon House
[3] including 1 joint with the Night Shelter

NOTES

[1] The views expressed in this report are those of the author and do not neccessarily reflect those of the Elmore Committee, the project Sub-Committee or the Elmore Community Support Team.

[2] These two definitions are slightly altered from previous versions (see, for example, the Elmore Committee's 1987 report) in order to render them less ambiguous.

[3] A 'recharge' basis means: the Committee employs the CPN through the Health Authority and pays the Health Authority for his services. The CPN is thus independent of the Health Authority (the Committee has a separate contract of employment with him) but he retains his Health Authority status, pension rights and so forth and is able to return to work there, though not necessarily to his original post.

APPENDIX 1

OBJECTIVES OF THE ELMORE COMMUNITY SUPPORT TEAM

The objectives of the team set out below are taken from the original project proposal supplied to the Department of Health.

These objectives are:

1. To create a flexible and highly responsive team for those DTP individuals who have slipped through the existing provision and need guiding back to it.

2. To offer community support to those individuals identified by agencies as being at risk of becoming DTP, who, with appropriate support, could be helped to stay in a stable position within the network of existing provision.

3. To identify suitable accommodation in the community with the co-operation of the housing agencies.

4. To provide follow-on support to individuals and agencies. Having placed an individual within the existing network of provision, close liaison with the agencies concerned and continuing involvement with the agency workers and the client would be required to promote the individual's chances of stability.

5. To offer support to DTP clients who appear before the courts where they pose difficult sentencing problems because of the lack of suitable disposals.

6. To offer the resources of the team for education and training about the DTP and ECST to workers, volunteers and agencies.

7. To promote network liaison at a high level. Existing inter-agency co-operation is already a feature of provision. This will be encouraged and strengthened, and extended to include discussion at all levels.

8. To evaluate progress and achievement in these objectives, and gather further information about the factors leading individuals to become DTP and about effective methods of intervention and prevention.

APPENDIX 2

PLACEMENTS UNDERTAKEN BY COMMUNITY SUPPORT TEAM MEMBERS AS PART OF INITIAL INDUCTION TO TEAM

The following list includes half-day visits to agencies as well as placements over several days, but does not include visits by the whole team to agencies to explain its function and discuss potential liaison, or further visits to agencies which took place in January 1989. The visits and placements mostly took place in November and December 1988.

Agency	Number of days			
	Support Worker 1	Support Worker 2	Support Wkr 3/CPN	Administrator
Psychiatric rehabilitation ward	3	1/2	*	1/2
Social Services Adult Team	3	3	-	-
Probation Day Centre	3	3	1/2	3
Police station	1/2	1/2	-	1/2
DSS offices	*	1/2	-	1/2
Luther Street Clinic (surgery for the homeless)	1	3	1	1
Chilton (detox) Clinic	1	1	*	1
Ley Clinic (residential community for people recovering from drug/alcohol problems)	1/2	1/2	*	1/2
Housing Department	3	3	2	-
Simon House (hostel)	1	3	1/2	1
Church Housing (hostel)	1	1/2	1/2	1/2
Night Shelter	*	1/2	1/2	1
Night Cellar (for under-26s)	*	1/2	1/2	1/2
Windmill House (staffed hostel/bedsits)	-	1/2	1/2	1/2
Local recovering alcoholics' hostel	1/2	1/2	-	1/2
Local housing association	1/2	1/2	-	1/2
Housing Aid Centre	1/2	1/2	-	1/2
MIND (Mill and Acorn day centres)	2	*	1	*
Porch (drop-in centre)	1/2	1/2	-	-

Total number of days on placement = 62

* = worker already had substantial experience of these agencies

APPENDIX 3
GUIDELINES FOR AGENCIES REFERRING TO THE TEAM

The following guidelines were supplied to all interested agencies early in January 1989:

GUIDELINES FOR REFERRAL OF 'DIFFICULT TO PLACE' CLIENTS

The 'difficult to place' are a miscellaneous group the nature of whose problems make them hard to deefine. It is in many ways more useful to attempt to define them in relation to the difficulties experienced by those agencies trying to categorise them. By working with those difficulties the Elmore Community Support Team will be a resource responsive to both client and agency needs.

The following information will give you basic guidelines on some of the characteristics the team have used to identify 'difficult to place' clients and on the different methods of referral. The Elmore Community Support Team asks agencies to consider these guidelines before referring a client so as to facilitate good working relationships and encourage appropriate referrals.

1. 'Difficult to place' refers to the difficulties that agencies have with some clients who do not clearly fall within the responsibilities of a single agency, it does <u>not</u> simply refer either to difficult clients or those who are difficult to house.

2. Clients should display multiple problems rather than single, intractable problems; combinations of some or all of the following are likely: homelessness, general health, alcohol/drug use, lack of social skills, offending, mental disorder.

3. The client is likely to display bizarre or disordered behaviour.

4. Referring agencies should be clear about any other existing responsibility for the client, so as to avoid duplication of support services.

Referrals can be made by letter, by telephone or by direct contact with a team member, no referral form is required. As much relevant detail as possible should be available at this point to enable the team to make an assessment.
The team will either offer an immediate interview or refer the case on to its weekly team meeting, dependent on the urgency of the case and on existing work loads.
The office will be open Monday-Friday, 9.00am-5.00pm. An answer-phone will take messages at all other times and the team will make contact as soon as possible.

If you have any queries about identifying or referring clients please contact us at the above address.

APPENDIX 4
MEMBERS OF THE ELMORE COMMITTEE, THE SUB-COMMITTEE AND THE COMMUNITY SUPPORT TEAM

The Elmore Committee is a voluntary body with charitable status, which has been in operation in Oxford since 1968. As a result of its work with offenders and ex-offenders in Oxford, the Committee convened a meeting in the Town Hall to consider the needs of mentally disturbed people in the city. This resulted in the formation of a working party, the later employment of an action research worker, publication of the 1987 research report, *Support for difficult to place people in Oxford,* and the eventual setting up of the Elmore Community Support Team. The Committee takes overall responsibility for the Elmore Community Support Team and is concerned with broad policy issues as well as the future funding of the project. Members of the Committee, some of whom joined at the inauguration of the team, are as follows:

Mrs P. Vereker J.P.	Chairman of the Elmore Committee
Mr G. Beard	
Rev. T.S.M. Williams	
Mr C. Rivers	
Mrs S. Matthew	
Mr B. Phillips	Treasurer of the Elmore Committee
Dr H. Allinson	G.P., Luther Street Centre
Mrs J.P. Brookes	
Dr M. Orr	Unit General Manager, Mental Health Services; Consultant psychiatrist
Ms C. Angel	Assistant Director of Housing, Oxford City Council
Miss M. Timbrell	
Mr P. Butler	
Mr R.W. Elmore	
Mr P. Patrick	Chief Probation Officer
Mr B. Durham	
Mrs A. Nyman	
Mrs C.A. Livingstone	Secretary of the Elmore Committee
Mrs M.C. Roaf J.P.	Special Needs Teacher
Deputy Chief Constable B. Rutherford, Thames Valley Police	
Ms J. Carr	Divisional Director, Social Services

Dr. Jon Vagg was a member of the Committee until April 1989.

Committee meetings are also attended by Jon McLeavy and Penny Rhodes.

The 1984 working party on the difficult to place became a sub-committee of the Elmore Committee. It meets monthly and is responsible for the day-to-day management of the Elmore Community Support Team. Members of

the Management Committee, some of whom joined at the inauguration of the team, are as follows:

Mrs P. Vereker J.P.	Chairman of the Committee
Dr P. Agulnik	Consultant Psychiatrist
Ms P. Goodwin	Senior Probation Officer
Ms S. Raikes	Housing Development Officer, Probation Services
Mrs C. Roaf J.P.	Special Needs Teacher
Mr N. Welch	Prinicipal Psychiatric Social Worker
Mr R. Temple	Cherwell Housing Trust, Special Projects

Management Committee meetings are also attended by Jon McLeavy, Penny Rhodes and Nina Nowakowska

The Elmore Community Support Team began in Sept. 1988 with the employment of the co-ordinator; three other members of the team joined in Nov. 1988 and one in February 1989. The original research worker, Jon Vagg, moved to a post abroad, and his successor joined the team in March 1989. Members of the team are:

Jon McLeavy	co-ordinator
Lesley Dewhurst	support worker
Angela Stannard	support worker
Bill Trotter	support worker/CPN
Penny Rhodes	research worker
Nina Nowakowska	administrator

Julie Ecclestone, money management project worker with Social Services, has been placed with the team for one year.

Elmore
Community Services

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