Inhabiting the Margins

The Elmore Model and Working with People with Multiple Needs (2001)

Report commissioned by

Elmore Community Services

Homeless Oxfordshire
Housing today, hope for tomorrow

ELMORE TEAM, OXFORD - GOOD PRACTICE REPORT

inhabiting the margins

homeless *alliance*

National Homeless Alliance is the membership body for organisations and individuals providing services and support to homeless people. We have 1,000 members who work with around 30,000 homeless people every day. National Homeless Alliance works in partnership with its members to:

- influence policy at local and national levels
- produce good practice guides and quality guidance to improve services for homeless people
- provide information to members through our website and magazine
- generate new funding for agencies working with homeless people
- improve public understanding of the issues around homelessness
- carry out research to better inform work around homelessness.

Lesley Dewhurst has been a member of the Elmore Team since its inception in 1988, first as a support worker and as manager since 1995. She has a background in direct access accommodation and was instrumental in setting up a low-cost women's counselling service in Oxford.

Pip Bevan has worked in the fields of mental health and homelessness for the past twenty years:

- Richmond Fellowship
- Patchwork Community Housing
- St. Mungo's Association
- National Homeless Alliance

The National Homeless Alliance **multiple needs project** is an innovative three year programme which aims to raise the quality and level of support provided by agencies to homeless people with multiple needs by providing good practice models of support. It does this by bringing together the disparate material written on this subject, researching models of good practice and producing mechanisms for disseminating good practice methods of working to staff working with this client group. Most of the project's work focuses on London but it has a national remit. It is staffed by a co-ordinator, assisted by an advisory group of experts such as homeless agency staff, medical and academic practitioners, and representatives from other interested parties such as the Rough Sleepers Unit.

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inhabiting the margins

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The Elmore Team works with people with multiple needs in the City of Oxford.

National Homeless Alliance seeks to enable, facilitate, and empower agencies to promote the good practice of their work.

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THE ELMORE TEAM, OXFORD

national homeless alliance
the voice of 1,000 frontline agencies

Preface by Pip Bevan

This report is aimed at agencies with an interest in effective models for working with people who have multiple needs. The Elmore Team model is not perfect but it is effective and its principles are sufficiently clear and simple for it to be used and re-interpreted for differing situations elsewhere.

In the late 1980s, people with multiple needs, identified by agencies in Oxford, were called the 'difficult to place'. They were always on the very margins of services, but never really engaged with them. Or they were the people who were excluded by the referral criteria of the various services.

These criteria have become stricter over the years as budgets have been squeezed, forcing people with multiple needs into further exclusion. The pioneering work of the Elmore Team is all the more remarkable as the people they work with were not a recognised client group when the team was set up in 1989.

Who are people with multiple needs? The following definition, which National Homeless Alliance has been working on for the last year, might help. A typical homeless or ex-homeless person with multiple needs often presents with three or more of the following, and usually lacks effective contact with services:

- mental health problems
- misuses various substances
- personality disorders
- borderline learning difficulties
- physical health problems
- offending behaviour
- presents with challenging behaviour
- vulnerable because of their age

Where one issue is resolved, the others will still give cause for concern.

Looking back through the papers and reports of the Elmore Committee, it is surprising how accurately the client group were described, particularly in *Support for Difficult to Place People in Oxford* (Vagg, 1986) which Jon Vagg wrote as a precursor to forming the Elmore Team. Even more amazing is how the model for engaging with this client group, employed by the Elmore Team, has stood the test of those years. It is still powerful.

Overview of the Elmore team

The Elmore Team is client-led. A support worker assesses an individual's needs and the team then works with them for as long as necessary. As one member of the team remarked: "You can stay with some people for a long time, constantly plugging them in to local services." Though some clients only need support for a limited time, a small number will need support indefinitely so the team offer an open-ended service.

Traditional outreach work aims to make services accessible when a client needs them. The Elmore Team takes a more direct approach, persistently trying to engage the client, and making all potential avenues for treatment and support open and accessible to the client. 'Plugging' people into local services is vital to the Elmore Team's way of working. The model can be broken down into four sections: assessment and engagement; co-ordination; advocacy; and brokerage. These elements are looked at in detail in the body of this report.

Most Elmore Team work is direct with clients. However, in some circumstances, they may not even need to meet the person to have a crucial role in brokering (or rebrokering) their services. One of the team's main areas of expertise is their knowledge of local agencies and services.

Clients are allocated a particular worker but it is important that they are seen to be the responsibility of the whole team. When one worker takes planned leave, all caseload clients are allocated to another team member.

The value of 'moving' a long-standing client around the team is widely recognised and supported by the clients. Elmore also encourages honesty; if one worker's approach isn't working, they will say 'this is not working', discuss it with the team and another worker will be allocated to the client.

In March 2000, the Elmore Team surveyed 105 local agencies and all current clients. Most rated Elmore's service either 'good' or 'excellent'. The team recently received 'Investors in People' status, demonstrating high standards for policies, procedures and development plans. The Elmore Team has much to offer and share. We hope you will find this report on them accessible, relevant and useful.

Contents

Chapter one: The client group

Picture a client whose chaotic behaviour leads to his being barred from support agencies, whose ill-defined diagnosis of mental illness means he seldom gets the help he needs, whose drug use makes him impossible to house, whose eccentric and bizarre behaviour puzzles all who meet him.

This is a very familiar picture to most agencies, one that often causes frustration or sinking hearts, wanting to help but having neither the time nor the structure to offer much more than a sticking plaster.

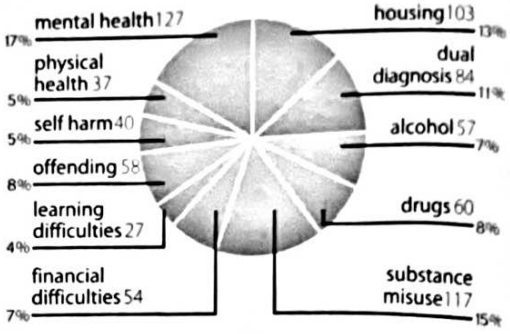
Agencies are constantly changing. The process of setting up a new service or altering an existing one to fill a gap, makes it necessary for agencies to draw new boundaries. Inevitably, if they are to provide the best service to the majority, a tiny minority will have to be excluded. These are the Elmore Team's clients.

The Elmore Team works in the City of Oxford. Its clients are single adults with complex, multiple needs who do not fit easily into services and are marginalised by boundaries set by other agencies. By and large, their problems have remained the same since the team set up in 1989, having any combination of the following:

- mental health problems (including personality disorders)
- substance misuse (including 'dual diagnosis')
- offending behaviour
- accommodation difficulties
- a learning disability
- bizarre or challenging behaviour
- money management problems
- physical health problems
- frequent self-harm

Particular features of Elmore team clients

The Elmore Team is often asked to describe a typical client. This is difficult since, to a certain extent, all clients are miscellaneous; the main reason why the team's intervention is necessary! However, statistics show that 95% of clients have some kind of mental health problem. This might be a 'severe and enduring' mental illness, such as schizophrenia or bi-polar disorder. It might be anxiety or depression. Or it might be a personality disorder. The team classifies a mental health problem as 'something about someone's mental health that is causing them a problem', preferring only to use formal diagnosis as a way of accessing services.



Typical known needs of Elmore Team clients from 1999/2000 statistics. Mental health, substance misuse and housing top the list of known problems.

Another problem frequently experienced by Elmore Team clients is substance misuse. Dual diagnosis of mental illness and substance misuse is now quite well documented but services for this client group are still very patchy, more so if other problems cloud the picture. A client may have a head injury or other physical health problem, a tendency to self-harm, or they may be in and out of the criminal justice system.

Approximately one fifth of the team's clients have some kind of borderline learning disability or brain damage, which manifests itself in a similar manner. It is particularly difficult for individuals to find their way around the complex network of services if they have a learning disability, misuse drugs or alcohol and have an underlying mental illness. This is familiar territory for the Elmore Team.

Problems with housing and finances are generally part of the picture. Indeed, difficulties in these areas are usually the precipitating factor for the initial referral. The team works with people in a wide range of circumstances: owner-occupiers, rough sleepers, people in temporary accommodation, hostels and shelters, and tenants of private and social landlords. Most clients receive state benefits, though some have independent incomes or trust funds. A small minority are employed.

Elmore Team clients have one thing in common; for a variety or reasons, they are not getting the services they need:

- The client is **too chaotic so the services they need cannot cope.** Elmore Team clients tend to be poor at keeping appointments and often behave inappropriately when they manage to.
- The client **does not fit referral criteria for services** either because each individual problem is too low for the threshold, or because of their particular cocktail of problems. People with multiple needs are always the exceptions to somebody's rule.
- The client is **unwilling to engage.** The client often distrusts statutory agencies and may refuse services even if eligible.
- Confusion over **which services should be involved.** Multiple problems results in multiple agencies. This can result in a lack of overview and a lack of clarity.

Family involvement

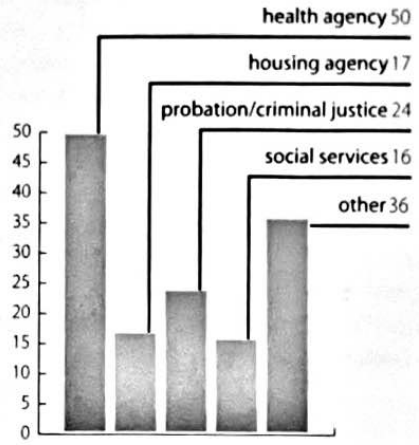
The team works with clients as individuals even if they are part of a couple or wider family. Some clients have children, occasionally living with them but more often in care or with an ex-partner. Sometimes other family members are very involved in the situation, such as mothers, fathers, or grandmothers. Intermittently the client may live with them. These people are integral to the client's life.

The worker has a balancing act to perform. They must be there for the client but also be very aware of the dynamics of the client's relationships with their family. It is very likely that 'significant others' will also have professionals involved with them. In some cases, a couple could each have an Elmore Team worker.

Where children are involved, the Elmore Team worker takes a secondary role; being there for the client (mainly advocacy and emotional support) but also supporting and enabling social workers and other professionals meeting their duty to the children. It is very important to be clear about the Elmore Team worker's role because the legal ramifications are complex and the outcomes can be very serious. The worker has a duty to report concerns about children or other vulnerable people if they believe their client to be guilty of abuse of any kind, yet they are primarily there to support that client.

Referral process

The team makes it its business to offer support to any individual over 16 years of age with multiple problems, who is in the City of Oxford. The referral process is deliberately simple: a phone call will suffice.



Typical source of Elmore Team referrals, from 1999/2000.

Referrers are encouraged to contact the team even if they are not sure that a referral is appropriate. In the team's experience even just discussing the case can help a referrer think through a complex problem and the possible courses of action. The team may not need further involvement.

Referrals come from an enormous range of sources: professionals in other agencies (health, social care, housing, criminal justice, voluntary sector), concerned members of the public, and from family and friends. The team also takes self-referrals.

The team also operates a street outreach service. This is mainly targeted at people who have multiple needs and sleep rough, though the team also makes contact with people who spend most of their time on the streets but do have accommodation.

The team gets approximately 150 referrals a year. Of these, 70% receive some form of active intervention from the team, and a quarter are taken on as long-term clients. The team endeavours to give advice and information to the referrers of the remaining 30% who either do not fit the team's criteria or leave town before any assistance can be offered.

Once a referral has been received by the team it can either be discussed and allocated at the weekly team meeting or can be responded to more quickly if necessary, sometimes immediately, providing support staff are available.

case study: arthur, 46

Arthur has swollen, ulcerated legs and schizophrenia with obsessive compulsive disorder. He was in and out of accommodation, eventually ending up sleeping rough. His major presenting problem is his compulsive behaviour which causes difficulties with housing. Arthur visits skips and bins around the city on his bicycle all day, collecting items (mainly paper) and storing them in his room until it is too full to get into. We had known Arthur for two years before he took to sleeping rough regularly. He finds it very difficult to acknowledge that he has problems so attempts to get him to clear his room/flat did not work. Nor did efforts to engage him with medical professionals. Ironically, once he was sleeping rough, it became a lot easier to work constructively with him. The main problem as Arthur saw it was that, sleeping rough, he had nowhere to store the items he collected each day. He was now willing to work on his problems so that he could find and keep accommodation. His physical health was also deteriorating. He was too busy to eat properly, and too busy to see the GP to dress his ulcerated legs. Even though Arthur was now receptive to help, he was extremely difficult to find on the streets. His busy round of skip and bin visiting meant that he never kept appointments and his whereabouts were very unpredictable. Most of the resulting work took place on outreach sessions or chance meetings with Arthur in the street: encouraging him to re-present at the homelessness unit, liaising with hostels, getting him to visit hostels, negotiating terms with the hostel that ultimately offered him a place. It took two months, at the coldest time of the year. Arthur has maintained his hostel place for six months but it has not been an easy time. His keyworker at the hostel has worked very closely with both Arthur and the Elmore Team, setting limits on how much Arthur can store in the room and what the hostel can tolerate. We have also linked him to a psychologist who is exploring other options with him. His legs are improving. He is glad not to be on the streets any longer but still has little insight into his problems. Progress is, and will continue to be, slow.

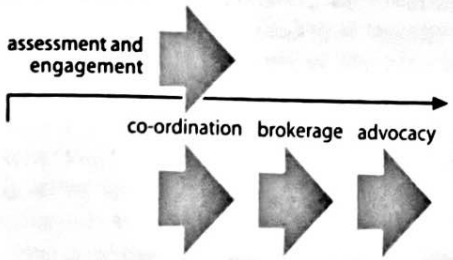
Chapter two: Operational work of the Elmore Team

Methods of intervention

What does the Elmore Team actually do? The workers offer flexible, peripatetic support which can be tailored to the needs of the client and the situation. They can work on practical tasks and emotional support. This can be for a day, a month, a year or – in some cases – over an indefinite period of time.

This support can float in and out of the client's life, depending on circumstances and the involvement of other agencies. The main aim of the intervention is, initially, to stabilise the situation before trying to set up more sustainable support systems for the future. Much of this will involve 'plugging' the client into appropriate services.

The Elmore Team is not particularly conscious of working to a specific model. However, the team has developed a distinctive way of working over the years involving four processes:



Before a client is accepted, preliminary enquires are made to assess the situation and the appropriateness of the referral. Once a client is accepted, the support worker attends to any immediate needs the client has, generally starting with practical issues like housing or benefits. The worker then builds up a picture of the client's situation and the surrounding circumstances, including the client's wider needs.

At the heart of this process is the relationship of the worker with the client. Elmore Team clients are often very difficult to engage and are generally jaded by past experiences. Building up a trusting relationship is central to the role of the support worker.

It is very helpful that the Elmore Team do not have a statutory role; they have nothing to offer the client, except themselves. Other agencies may have less success with this client group because their role as landlord, nurse, social worker or probation officer brings an unhelpful power dynamic to the relationship, no matter how skilled the individual worker may be.

Co-ordination

It is often the task of the support worker to make sense of the wide range of agencies that can or might be able to offer a service to the client with multiple needs. This might involve arranging a case conference, or simply linking agencies together that were unaware of each other's involvement.

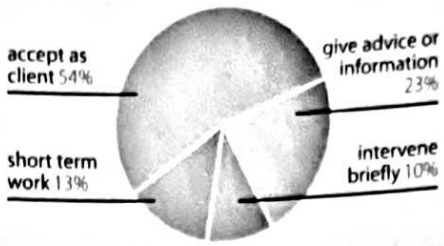
One of the strengths of the team's inter-agency work with clients with multiple needs lies in the process of negotiation to ensure agency co-operation. Without this, co-ordinating services is very difficult. A lot of discussion of inter-agency work focuses on co-ordinating services, but the significance of negotiation is often missed or ignored.

Advocacy

To arrange a total package of care, each component must be clearly defined and negotiated with the agency concerned to ensure their willing co-operation. The team workers act as the client's advocate by presenting their needs to the agency, accompanied by the client or without them.

Each agency then takes on responsibility for their own particular service. Someone needs to co-ordinate the services and to ensure that the whole package remains in place. At times when the client has no statutory keyworker, the Elmore Team support worker will take this co-ordinating role.

Typical Elmore team response to referrals, from 1999/2000.



Brokerage

The team has developed a number of alternative approaches for varying situations. It does not necessarily retain the case-management role if it would clearly be more appropriate to hand this over to another agency. There is a range of potential outcomes:

a The team worker takes primary responsibility for assessing the client's needs and negotiating a care package. The worker retains the role of case manager and works directly with the client.

b The team calls a case conference of agencies involved with the client, to assess the client's needs and negotiate a package of care. The team worker may then take a less central role with the client but continues as the case manager, co-ordinating information and ensuring that the package remains in place.

c The team hands over the role of case manager to another agency and withdraws from the case.

d The team's role may be limited to supporting workers in other agencies but, nevertheless, remains prepared to take over a more active role in the package if it becomes necessary.

e Short-term interventions:
- A package of care has broken down and the client needs guiding back to re-engage with services.
- Crisis intervention when a client's behaviour becomes very bizarre or difficult and immediate action is required to resolve the situation.

Summary of Elmore Team interventions

No contact with client:

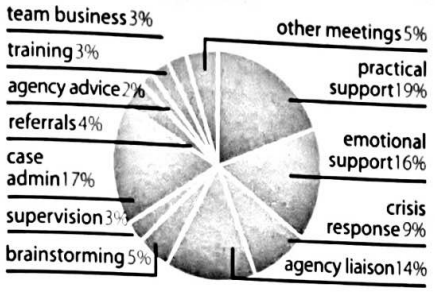
- Advice given over the telephone to another agency.
- Revitalising existing agency involvement that has fallen by the wayside.
- Organise and host a case conference which involves any relevant agencies or personnel. Potentially, all work generated is then delegated back to other agencies and Elmore Team involvement terminated.
- Maintaining a watching brief of potential clients, ie. people who are presenting at agencies, seen around the city and exhibiting behaviour that would indicate that they had high needs, but seem impossible to support or are refusing support. Elmore Team frequently takes on the role of 'information gatherers' for these people, attempting to make use of opportunities to engage the client if they arise and keeping agencies informed where necessary.

Contact with client:

- Assertive outreach: spending time trying to engage potential clients who are unwilling to accept help.
- Building up a relationship with the client where no one else has had time or the brief to do so. Potentially discovering new steps for the client to take.
- Advocacy between client and agencies where trouble has developed or a client is finding it hard to put across their point of view. For example with the housing department, police, or magistrates courts.
- Supporting agencies where a client is causing problems, perhaps by finding day care for the client to ease the situation.
- Negotiating a better deal for the client from the agencies.
- Negotiating with agencies to try something new.
- Collecting a central pool of information on the client to help prevent confusion over the care and support offered.
- Providing practical support, mainly tasks connected with housing or benefits. However, this could also include tasks like car lifts, flat cleaning if necessary, curtain rail fixing etc.

- Being available in times of crisis, possibly appearing in court, visiting police cells, organising a section under the Mental Health Act, and arranging hospitalisation if necessary.
- Liaising with other involved agencies at all times to avoid duplication of work and to work together satisfactorily where appropriate.

An approximate breakdown of how an Elmore Team support worker allocates his or her time each week. The Elmore Team offers a Monday to Friday service, from 9am to 5pm. However some outreach and client work takes place outside office hours, in the early morning or evening.



Aspects of Elmore Team work

Assertive outreach

It is a feature of this client group that they do not respond well to being in any particular place at a particular time. The team has had to adopt very pro-active ways of working with individuals. Clients are seen where it is practical to do so: in hostels, day centres, at home, in cafés, on the street, or wherever they happen to be.

Initial approaches may be rejected. In this case the worker will persevere, sometimes over several months. Different tactics will be tried to find and engage with the client. For instance, financial support is sometimes welcomed where medical advice is not. Talking through letterboxes, engineering 'chance' conversations, repeatedly finding ways of offering support.

The Elmore Team worker needs to be creative and flexible. Even once support has been accepted, maintaining contact can be a difficult business. The team use 'targeted outreach' sessions to keep up with more elusive clients. Input to the client can be shared throughout the team, with one support worker maintaining the nominal lead role. Opportunistic encounters may be used with a lot of work done ad-hoc.

'Watching brief' work

With some individuals, even the persistent approach does not work; yet they clearly have high levels of need. The Elmore Team continues to keep these people on their client caseload, by maintaining a 'watching brief'. Working closely with agencies at 'ground level' means that the team members can often pick up small bits of information which, considered together, indicate evidence of heightened risk or a particular need for intervention. The team will record this information and liaise with other agencies, where appropriate, repeating offers of support at every available opportunity.

Work in the criminal justice system

The Elmore Team has had close working links with the courts and probation service since its inception. Initial research carried out before the team was set up, found that about 75% of the client group had records of offending so it was clear that the team would be involved with clients who would appear in court.

Mentally disordered offenders pose intractable remand and sentencing problems, particularly where the offence is a nuisance to the public rather than a serious danger. A hospital order may not be appropriate and a custodial sentence is not warranted for this type of offence. It is also often clear that the defendants need care and protection. Although this is not strictly the court's responsibility, it nevertheless arouses a sense of obligation in many magistrates who recognise that a mentally disordered offender is likely to re-offend unless steps are taken to establish them in a more stable way of life.

From day one, the team has offered a speedy response to the courts. In the early days this was often precipitated by a duty visit from a probation officer to the court cells first thing in the morning. The support worker would be required to attend as soon as possible if someone with multiple problems was detained and there was no other support immediately apparent or available.

The support worker could then spend time with the client. Not only were they able to give a quick assessment of the situation, they could find out who else might be involved, whether the client had anywhere to live, get their medical history, and establish their current circumstances. This helped the magistrate to reach a sensible and quick conclusion about disposal, and meant that the client also had support. In many cases this would continue beyond their court appearance.

For some years, a community pyschiatric nurse (CPN) was based within the Elmore Team as part of a local court diversion scheme, with part-time input from a psychiatrist. This placement followed indepth research undertaken by the Elmore Team into local provision for mentally disordered offenders. However, Home Office funding for the court diversion service was discontinued in 1997 as it was felt that the relatively low number of clients did not justify the full time employment of a CPN.

Elmore Team support workers still work in the courts today, though less frequently than ten years ago. This is due to a combination of factors: better mental health training for police custody suite officers; changes to the Crown Prosecution Service; an arrest referral scheme for substance misusers; and improved services from community mental health teams. However, it remains an important part of the service.

Outreach to rough sleepers

Before the Rough Sleepers Initiative (RSI) funded a street outreach service, the Elmore Team were already in contact with many people who were sleeping rough. The RSI funding gave a new focus and direction to this work. The team now works closely with other rough sleeper agencies in Oxford, particularly the Salvation Army outreach team, jointly trying to engage with rough sleepers who have multiple problems.

Specific project work

Over the years, the Elmore Team has taken on several discrete pieces of work which fitted well with its core work. These include:

- **money management action research**
- employing a **continuing care worker** to support clients with long term physical health problems exacerbated by a homeless/rootless lifestyle, linked to the social services HIV team (including HIV housing development)
- **mentally disordered offenders action research** (discussed earlier)
- research into **local responses to dual diagnosis**, culminating in a report and conference

The team is currently engaged in several local partnerships. In all cases, client work has been incorporated into the team's general support work, with specific support workers taking a lead to extend and develop local networks and strategies for each project. The partnership projects are:

- work with **older homeless people** (funded by HACT/Help the Aged) in partnership with Connection (a local floating support team).
- work with **single, vulnerable people in East Oxford** (funded by East Oxford Action) in partnership with Connection and Oxford Night Shelter.
- work with **young offenders with multiple problems**, in partnership with the Oxfordshire Youth Offending Team.

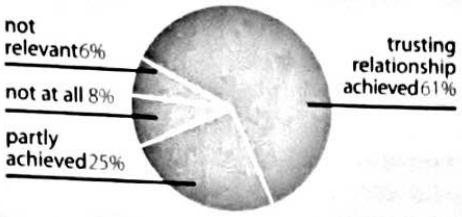
The Elmore Team makes excellent use of the team's broad skills base and its position within the Oxford network of agencies, while keeping to the basic remit of the team to support people with multiple problems.

Monitoring outcomes

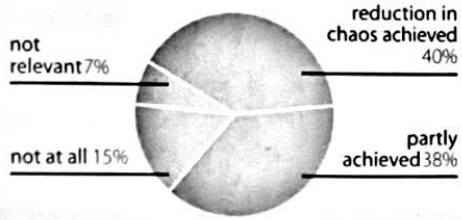
The team has struggled over the years to find a satisfactory way of measuring outcomes. Though all Elmore Team clients have multiple problems, each is different. For instance what might be a significant 'reduction in offending' for some people could seem negligible if applied to others. However, the team has made some progress in establishing four particular areas where it does seem possible to assess outcomes.

The team's starting point was thinking about the hallmarks of Elmore Team clients. They felt that, in most cases, Elmore Team clients are difficult to engage, chaotic at the point of referral, have problems with accommodation and are not in contact with appropriate agencies. They came up with four questions, graded as being either wholly achieved, partly achieved, not achieved at all or not relevant to that particular client. The questions are:

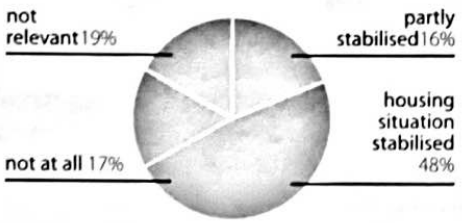
Has the client formed a trusting relationship with the support worker?
At the point of referral, most Elmore Team clients are wary of professionals and usually unwilling to engage. This is frequently a block to their getting support or accessing services.



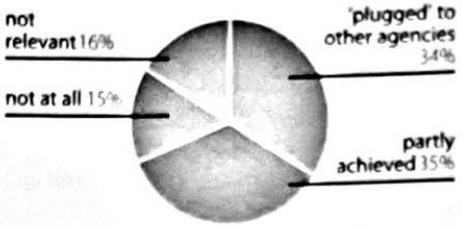
Has there been a reduction in chaos surrounding the client during the last year?
People with multiple problems tend to have an air of chaos around them, either because agencies do not know how to offer appropriate support or because of the actions of the clients themselves.



Has the client's accommodation situation stabilised during the last year?
Even if a client has a home, it is often in jeopardy.



Is the client using other agencies appropriately?
At the point of referral this is rarely the case and it is one of the main tasks of an Elmore Team support worker to endeavour to 'plug' clients into agencies where relevant.



case study: ronald

It is difficult to say how old Ronald is or what his real name is. After nine months of observation, repeated efforts to engage with him, tracking to see where he stayed, conversations with the police and concerned members of the public, and attempts to gather information about him, Ronald remains a mystery. However, what is clear is that Ronald desperately needs help. With the help of the community psychiatric nurse on the team we have been informally monitoring his mental state throughout the period. What at first was relatively unobtrusive - crossing himself repeatedly in the street, sitting for long periods in the same place, doing strange little dances on the pavement - has now become extremely obtrusive. He is neglecting himself badly, smells and appears to be covered in his own excrement. He is rumoured to carry a lot of cash and we are surprised that he has not been attacked - yet! The site of his rough sleeping (a public toilet) has been burned down and now he nods off on benches. We feel that it is now time for more urgent action and are activating a psychiatric assessment. This would necessarily mean police involvement. It is taking a lot of co-ordination but we hope it will eventually result in Ronald getting the help he needs.

Chapter three: Structure of the Elmore Team

Elmore Community Services (previously known as the Elmore Committee) is a registered charity and a limited company, run by a board of directors. It manages the Elmore Team. The team is made up of:

- one manager
- 6.2 support workers (full time equivalent)
- two part-time administrative secretaries (one full-time equivalent)

Profile of the team members

Role of the manager

The manager has an overall view of the project's objectives. She is responsible for managing the team, and for planning, organisation and monitoring. She supervises the workers and makes sure they are able to carry out their tasks effectively. She maintains good relations with clinicians and the top management of local agencies, keeping them informed of progress and developments. She is also responsible for public relations and responding to requests for training and information from other agencies.

Support workers

All support workers work to the same job description but have a diverse range of backgrounds, skills and qualifications. To aid the professional credibility of the team within mental health agencies, a community psychiatric nurse is on permanent secondment to the team. However, she works as a support worker rather than as a nurse.

Each support worker has responsibility for a caseload of approximately 20 clients at any time. By rule of thumb, a third will be very active, a third will be relatively stable and the remaining third will be undergoing the lengthy process of engagement or on the 'watching brief' list. Across the team this means an overall active client list of between 130 - 150 people.

Support workers are also involved in other areas of the team's work, depending on personal preference. Some lead particular projects, such as the work with young offenders. They also represent the team at network forums.

Three staff are practice teachers for student social workers or nurses, and the team is frequently host to students on placement or day inductions. Staff also provide training locally, particularly in mental health awareness.

Administrative secretaries (job share)

Having a well-run office base is extremely important to the team. Working in isolation much of the time, the support workers need a safe and welcoming place to return to. They also need messages communicated promptly and efficiently and to have someone based in the office who is sensitive to the needs of clients. The role of administrative secretary is therefore pivotal to the functioning of the Elmore Team. New workers to the team have commented on the difference this makes to their ability to cope with the inevitable frustrations and tensions of their job.

Recruitment

The skills mix of the team is extremely important. However, skills are not tied to professional labels, with the exception of the community psychiatrist nurse post.

When a post becomes vacant there is a team discussion about the skills and abilities that would be desirable in a new team member. There may be a particular slant to the work which is not being adequately met by the team. For instance, when the team first started providing outreach work to rough sleepers, it seemed appropriate to look for a person with experience of street outreach work.

Individual members bring so many skills to the team's work that there is a strong sense of sharing and continually upgrading the skills of all members. Current areas of knowledge, skills and experience held by the team include:

- social work
- mental health (inpatient and community)
- young people
- disabilities
- adult education
- drugs outreach work
- work with therapeutic communities
- adult literacy
- family work
- crisis advice
- women's groups
- HIV/AIDS work
- counselling
- motivational interviewing
- housing support
- direct access accommodation
- project management

The team is very aware that it often seeks something less easily definable in a new support worker than a particular qualification. To clarify this, the team devised a comprehensive list of competencies expected of support workers. This tries to pinpoint the qualities needed in a high calibre support worker. It has proved extremely helpful for both recruiting new staff and assessing their performance at the end of the probationary period. It also helps the support staff to see each other as Elmore Team support workers, rather than in terms of their previous professional lives.

Job description *see appendix on page 25*
Person specification *see appendix on page 26*
List of basic competencies *see appendix on page 27*

Retaining staff

The Elmore Team has an unusual track record in staff retention for a small organisation with no particular career ladder. Two employees have stayed with the team since it was set up in 1988. Two more have been with it for over eight years. The CPN has been connected to the team for eight years and employed directly for five. The four more recent additions to the team (within the last three years) all came into new posts.

Staff continuity is vital to the success of the team. All Elmore Team members are motivated and enthusiastic and there is a strong culture that might be disrupted by constant staff changes. The concept of the team's work is difficult to grasp immediately. It has vague edges that cannot be easily defined by written protocols and procedures.

Instead the team is steeped in its evolution, which new members pick up from their more established colleagues. The 'Elmore Team way of working' is subtle and relies on the skill and judgement of its experienced workers. The team has nothing to offer its clients but itself. If it lacks credibility and the ability to gain the trust of the people it works with, then it has nothing.

Trust

There is a healthy reliance on trust between the team members. This is greatly aided by staff continuity as trust takes time to develop. It is accepted within the team that working with this client group can be a difficult, frustrating and challenging process. They accept that some team members may work better with some individuals than others.

The trust and honesty, which has developed between support staff, enables a constant dialogue about client related problems that is healthy and supportive. Difficult client visits are discussed almost as soon as they have taken place. There is a high level of awareness between support staff of the work their colleagues are doing. Informal peer supervision and discussions about client work is encouraged.

The physical layout of the office encourages this, with support staff sharing three offices close to each other. The constant buzz of discussion when support staff are present in the office promotes creativity, initiative and energy. It is difficult to imagine whether this could be sustained in a bigger organisation.

Organisation of the team

Team members hold a weekly team meeting to develop and discuss working practices, making sure that there is a coherent link between policy and practice. Referrals are discussed and allocated at this meeting, and diary commitments divided up for the week ahead. This meeting also allows an essential exchange of information

about clients and other agencies. Lunch is shared before the meeting and guests from other agencies are often invited.

In between the weekly team meeting there is an informal exchange of ideas and information between team members. All the team try to spend part of their day at the office, recognising that lone working in the field is not always the best way to support people with entrenched problems. Periods of reflection and talks with colleagues can often provide the spark needed for a more creative way of working.

Risk management

With such a high risk client group, a key management task is ensuring the safety of all team members and having a sound health and safety policy that works well in practice.

The team takes a pragmatic approach to risk assessment, believing that systems need to be easily implemented and updated, or they will not work. If forms are lengthy they will not be completed properly and the more information asked, the harder it is to understand them.

When developing systems around risk and safety the team was very conscious of the need for good communication. If someone has been a client for a long time it can be too easy to assume that they are 'safe' but a recent event or incident may have changed things considerably. The support worker may be aware of this, as may one or two colleagues, but not necessarily the whole team, especially office-based staff.

On the other hand, people are often referred to the team with a fearful reputation for violence and aggression. Often this turns out to be rumour. For these reasons, the team has constructed a variety of simple and achievable procedures:

1 The **basic risk assessment form** completed as soon as possible after referral and structured around four simple questions:
   - Does the referrer know of any history of risk? (eg. violent incidents, aggression, sexual offences, self-harm, false allegations)
   - Have you checked with other agencies for further information, if appropriate?
   - What are the likely/possible triggers?
   - How do you intend to work with the client in light of this information?

   This form is kept in a prominent place in the client's file, so can be accessed by any other team member working with the client if the named support worker is away. It is updated when necessary and at each client's routine three month review. The team have very good links with the local police.

2 **Clients causing particular concern** are noted on a sheet kept in a prominent place in the office where all staff (but not clients) can see it. This details individuals who might call at the office who pose a heightened risk. It is particularly useful for identifying clients who would not normally present a risk who staff are likely to feel safe with, particularly admin staff who may not be privy to team discussions.

3 **Communication and liaison with other agencies** about risk is also important. It is team policy to share information on risk with any agency which might need to know. This is done without prompting, especially if the client is likely to turn up unannounced. The team does ask the client for their verbal permission to do this and records it in the client's notes. Getting a client's written permission is very much needsled. The team has also signed up to a local inter-agency information sharing protocol.

Backed-up by good information about potential risk, the team are able to use a variety of safe ways to work. Initial visits to new clients are conducted in pairs, unless another agency worker will also be present Further visits can also be done in pairs if it is thought necessary.

The team discusses ways to minimise risk with each client, including location, particular triggers, time of the day. Both this and a reporting back system are summarised in the health and safety policy which is a key part of induction for any new team member or student on placement.

The Elmore Team is able to work comparatively more safely with clients who present as relatively high risk than some other agencies. The support workers are not gatekeeping housing, money or medication. They do not wield any statutory power. This makes them less likely to be the butt of aggression. However, this is certainly no reason to be complacent and all team members are very aware of this.

Training

In many ways the team's workers need to be 'jack of all trades and master of none'. Their main expertise is knowledge of local agencies and networks. This requires constant updating and relies on a good flow of information around the team. Each support worker also needs a basic knowledge of areas related to the client group. Principally:

- mental health
- substance misuse
- criminal justice system
- learning disability
- housing and benefits legislation

Each area has been analysed by the team and a basic level of knowledge agreed as a benchmark for the annual training review. This review sets out the framework for training opportunities during the year. It is the manager's task to co-ordinate this, using supervision and annual appraisal to make staff development a continuous process. Staff are encouraged to take part in training events and to develop their skills regularly through other methods such as shadowing colleagues in other organisations.

The team regularly hosts a number of students under placement, either social workers or nurses. This enhances the skills of the team, and serves to disseminate the good practice of the team.

Supervision

All support workers have formal supervision with the team manager every four weeks. All cases are discussed in detail and work plans reviewed during the session. The support worker will also bring up any other issues concerning their work including training and development.

As mentioned earlier there is constant informal peer supervision throughout the team. Though support workers carry their own caseloads they need to be able to cover for colleagues during absence. They also need to be able to contribute to discussions about more problematic clients with knowledge and understanding. This combines the advantages of a 'whole team' approach with those of allocating cases to individual workers.

Funding

This has always been an extremely complex area. The Elmore Team offers services to people on the margins of other agencies' responsibilities. The knock-on effect is that the team also finds itself on the margins of funding allocations. This presents the following challenges for the team manager:

- Funders need to be persuaded that they have some **responsibility for the client group**. A core group of local funders have been involved with the team since it was set up. They are:
  - social services
  - probation
  - housing department
  - health authority
- Local funders need to be supportive enough for the team to approach them for **extra support if there is a funding crisis**. The team therefore needs to maintain a good relationship with them and keep a high local profile.
- Funders need to accept that they **fund all the team's services**, not just an area that interests them. This inevitably leads to multiple funding for each client, and service contracts need to reflect this. The Elmore Team has negotiated service contracts that are only loosely tied to numbers. With the exception of the Department of the Environment, Transport, and the Regions, contracts do not demand targets for clients reaching specific outputs. Instead, they look for a broader picture:
  - statistics relating to numbers of referrals
  - a breakdown of the problems experienced by clients
  - an outline of the current work of the team. This allows the organisation to

avoid tying referrals to specific funding sources. Indeed it would be impossible to decide who exactly was funding work with a client who was offending, mentally ill, self-harming, substance misusing and sleeping rough.
- Funding needs to be spread across a wide range of sources to give stability.

It has become increasingly difficult to maintain the level of funding needed to run the Elmore Team at current levels. Local statutory funders cannot always afford to increase their grant in line with inflation and, in some years, there have been cuts though they have been comparatively small. The current trend is to fund new innovative projects rather than old innovative projects like the Elmore Team. One solution has been to find relatively short-term funding for specific pieces of work related to the Elmore Team's core aims and objectives. In the past four years, the Elmore Team has widened its funding base to include money from:

- DETR/DoH (outreach to rough sleepers)
- Oxfordshire Youth Offending Team (16-17 year olds with multiple needs)
- Help the Aged/HACT (older homeless people)
- East Oxford Action (vulnerable homeless in East Oxford)

These comparatively short-term funding sources require constant attention, anticipating opportunistic funding and putting together bids at short notice. It is time consuming and feels like a distraction from core business. Grants are usually for three years or less and are often tapered.

On the positive side, the new projects add an interesting focus on specific client groups, which is good for all concerned (eg. work with older homeless people for Help the Aged/HACT). It is good for staff who learn new ways of working and acquire new skills and knowledge. It also requires partnership work with other agencies.

To help fill the gaps between short-term contracts, the team has been able to attract some money from charitable trusts. The number of different funders for the Elmore Team's comparatively small annual revenue costs is now into double figures.

case study: sue, 30

Sue was first referred to the team in 1993 by a housing association worker. Her five daughters had been taken into care and Sue was very depressed and misusing solvents. She was sectioned and admitted to Warneford Hospital over concerns of risk from solvent abuse. The Elmore Team withdrew support because so many other agencies were now working with Sue. Four months later we followed up Sue's situation to check that she was able to use the statutory support offered. This led to a second referral. Sue was sexually abused in care aged seven and had recently been raped. She had a history of overdose, self-harm, suicidal behaviour, and admissions to psychiatric wards. She had a long history of polymorphous drug misuse including a three-year heroin addiction. We began work with Sue on drug rehabilitation and jointly worked with probation on emotional and housing support but nine months later Sue withdrew contact. A third referral to the Elmore Team followed Sue's release from a prison sentence for street robbery in 1998. She had overdosed and been admitted to hospital several times. Her children were now officially adopted and her chaotic lifestyle even more entrenched. The Elmore Team referred Sue to supported housing; referrals to drug rehabilitation were repeated and advocacy work was needed as Sue contested the county court adoption decision. During the last two years the Elmore Team have given Sue emotional support for post-traumatic stress resulting from the rape as an adult and sexual abuse as a child. She gets housing support, practical support like benefits liaison and joint work with the City CMHT and voluntary agency drug workers. In the last eight months there has been a relative reduction in her chaos and her drug use has reduced considerably. Hospital admissions are down though concerns remain over suicidal behaviour. Sue is far more open to support. Periods of respite in a therapeutic community provided an alternative to hospital admissions while Sue was waiting for funding for a drug rehabilitation placement. Being able to offer long term, flexible client-led, holistic support has provided some consistency to Sue's chaotic lifestyle and multiple complex needs. Slowly Sue is stabilising and can now begin effecting some positive changes in her life.

Chapter four The Elmore Team and the local environment

Networking

The Elmore Team occupies a disproportionately prominent position in the network of social care agencies in Oxford because its work crosses so many professional boundaries. It makes networking very important. Agencies refer to the team on a variety of matters such as getting information about a particular client, about network resources, or to get advice on aspects of case management. Other aspects of network involvement include:

- helping to maintain the feeling and continuity of the network in Oxford
- producing and regularly updating a directory of services in the Oxford network
- attending meetings to exchange information and share problems
- supporting new workers from partner agencies in their induction process
- presentations to people who are interested in the work of the team
- actively promoting new initiatives in the network to bridge emerging gaps
- developing local strategies

Statutory services – where the Elmore Team fits in

Covering such a wide client group, the Elmore Team overlaps with many different agencies. It is essential that the team's efforts do not distract from the work of statutory agencies. Careful thought goes in to this and it requires frequent updating as agencies expand or contract.

Since the Elmore Team began in late 1988, there have been many changes to the network of care provision in Oxford. Most notable are the:

- advent of the community mental health teams (CMHT)
- introduction of the Care Programme Approach (statutory framework for planning and reviewing post-discharge care for patients with a severe and enduring mental illness, known as CPA)
- changes in social services including the move from social work to care management
- formation of a team working with homeless mentally ill in conjunction with the community mental health teams.
- introduction of floating support team
- increased 'in-house' support for tenants of registered social landlords
- arrest-referral scheme for substance misusers,
- growth of local day-centre provision.

In some ways, these changes have made a difference to the work of the team. However, the sort of clients that the Elmore Team takes on and the style of their work has not changed at all. Nor have the elements that constitute a 'difficult to place' client under the Elmore Team's initial criteria changed.

What has changed are the agencies that the team interacts with. Client numbers have risen and the highest numbers of referrals still come from health and social services, the very agencies that have undergone the changes outlined above. To some extent this is caused by the strict remit of CMHTs, to only work with people with a 'severe mental illness'. This leaves the Elmore Team with a typical client group: people with personality disorders or diagnoses that are confused by substance misuse. The team also receives a steady stream of referrals of people who do not want to get involved with statutory services.

Community mental health teams

The Elmore Team is in regular contact with the city-based CMHTs, attending their team meetings periodically to discuss any clients in common and to pick up new referrals. The staff of CMHTs, particularly the senior nurses, seem to have a good understanding of the work of the Elmore Team. Personal links have been made with most of the nursing and social worker staff, and the team liaises with them regularly over clients

in common, and see them at meetings around the network. Most new staff members visit the Elmore Team as part of their induction package.

The clients that the team pick up from CMHTs are either people who have been referred to the CMHT but do not fit their criteria, or they are sufficiently chaotic and bizarre for the CMHT to feel that they would benefit from Elmore Team input. Referrals are made by the team to CMHTs (via the GP) as well as the team taking referrals.

Care programme approach – care management 'keyworking'

A proportion (approximately a third) of current active clients have a keyworker under CPA or a care manager from social services.

The amount of input from the keyworker varies enormously. In most cases the client will see the keyworker by appointment, usually every two to three weeks. The keyworker generally attends to the medical side of the client's needs (in the case of CPNs); giving depot medication, assessing psychiatric conditions, and arranging admission to hospital as needed.

The Elmore worker is more often the one who has the 'relationship' with the client and will be there for them in emergencies as well as for more pragmatic tasks; advising on benefits and debt, getting the client an appointment, and liaising with other agencies.

Elmore Team workers do not take on a keyworking role like their statutory counterparts. Nor does the team become a formal part of a statutory probation order. This is for good reasons:

- They would run the risk of alienating clients who respond to them precisely because they are not part of a statutory body.
- The team has never set out to duplicate services. Involvement in statutory provision would run dangerously close to this.

However, they are ideally placed to supplement and complement the work of keyworkers and co-work with them where appropriate. This is particularly helpful if the client refuses contact with the statutory worker, or attends [illegible] Elmore Team worker can often maintain the 'coal face' work, linking with the keyworker when necessary.

Clients without a keyworker

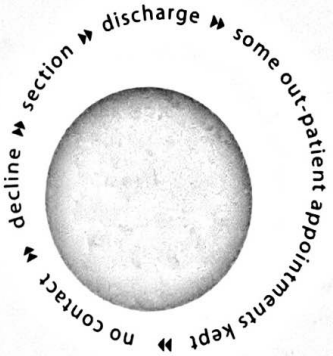
At least two thirds of the active cases do not have a keyworker under CPA or a care manager. This is because they do not satisfy the criteria for those systems. Most of them have a personality disorder. Others have physical problems, are substance misusers, have a slight learning difficulty, or a combination of these. The Elmore Team works with several clients who have a clear diagnosis of schizophrenia but who refuse any involvement with the psychiatric sector.

The team are very careful to refer people to CMHTs if they feel that they should be under CPA. This is discussed both at the point of referral, during supervision and case reviews. It may be that the clients who are initially refusing psychiatric help might eventually feel happier about contact with a CMHT. If this is the case then the team try to help make it happen.

Why the Elmore Team is different to other agencies

One of the Elmore Team's great strengths is that it can offer clients a service entirely tailored to their own needs, without the burden of statutory duties or pre-defined roles. This is frequently what enables the team to work with clients who have a history of refusing other forms of help.

Many of the Elmore Team's clients are very ambivalent about psychiatric input, either because they have no insight to their own



A typical picture of an Elmore Team client's contact with mental health services

acute illness or because they do not like medical treatment. Before CPA, this group's contact with mental health services was very intermittent. There was usually a cycle of no contact > decline > section > discharge > some out-patient appointments kept > no contact. Under CPA the route is kept open for contact/re-admission. However, the team's role is crucial to maintaining contact between the CPA keyworker and the client.

Over the years the team has followed an approach rooted firmly in pragmatic, client-centred work, allowing flexibility and space for the client in a way that frequently clashes with the professional agendas of other support agencies.

Where an Elmore Team worker co-works with a keyworker from the statutory sector the team must remember that it is not only offering extra time and flexibility, but a specialist service which can work with very difficult clients. Elmore Team workers are not there to supplement flagging services and are proud to offer a fresh perspective and working style unhampered by the constraints of statutory responsibility or a medical or social work model.

All or some of the services could be things that other agencies might do. However, those agencies are sometimes unable to deliver these services for a variety of reasons which the Elmore team specialise in getting round:

- restrictions made by the brief or function of an agency.
- client refusing to accept help
- agency unable to commit sufficient time to complete a task - it often takes a lot longer to complete even simple tasks with an Elmore Team client because of the nature of their problems
- agency unable to be sufficiently flexible to work with a client group that constantly 'changes the goal posts'.
- some agencies cannot work with clients who are drunk or who otherwise use their service inappropriately

Flexibility

Workers aim to be as flexible as possible. For example, they may walk around the city centre to find someone whose DSS form needs signing, will arrive at the night shelter before people need to leave to find someone who persistently misses appointments with the housing department, or spend the better part of several days tracing the birth certificate of someone who otherwise would not get their pension.

The team can respond quickly to crises, either involving a new referral or an existing client. As a small organisation with no statutory responsibility, the team can make quick decisions about how they can respond to a request. Getting a response from a CMHT, by contrast, involves a referral through a GP and discussion at a team meeting a few days later.

In theory, anyone who is in crisis and appears to have a mental illness can get help from a duty psychiatrist that day. However, if there is neither a clear diagnosis nor need for admission, the immediate needs of that person are likely to be ignored. In this crisis situation the Elmore Team is not there to assess anything other than immediate needs and can respond accordingly.

Durability

The Elmore Team will stay involved with someone for as long as they need their support. The team does not plan to complete a number of tasks and then terminate the relationship. Apart from rare occasions where a client poses an actual threat to workers, cases are only closed if the team has passed on all the work to other agencies, or if the client has requested it. Even if a substantial amount of the work is being done by other agencies the Elmore Team will stay in contact with the agencies and the client to ensure that all the client's needs are being met and to reactivate support if needed.

This may lead to extremely low levels of contact for a while, interspersed with much higher levels at other times. It lets the team keep up a relationship with a client in a far more sustained way than would be possible with a larger organisation where cases have to be reallocated every time they 'go active'.

The small Elmore Team get to know each other's clients, discuss them in team meetings and cover for each other during annual leave. The team also swap over workers with more long-term clients to give a fresh approach.

The upshot is that the client grows to trust the team and, in turn, this reduces the amount of chaos in their lives. The team can pre-empt crises by recognising patterns of behaviour and taking appropriate action earlier. They also help the client feel more stable by providing continuity.

Non-statutory

It doesn't mean that they don't need that help. On the contrary, long periods avoiding support usually lead to people with multiple needs having more problems, making it even harder to offer them help. The Elmore Team can offer a non-threatening accessible service simply because they have no connection with services that these people associate with bad experiences. Nor will the team begin working with them from any specific angle; they approach each new client with a completely blank sheet.

case study: jane, 28

Jane has been known to the Elmore Team for over five years. She was first referred by The Bridge (emergency housing for people under 25) after being taken there shoeless, by ambulance. She had been diagnosised schizophrenic and her three children taken into care. She had a brother in Oxford and wanted to stay here. But first she needed to be registered with an Oxford GP to get medication for her schizophrenia. An Elmore Team worker met her to try to establish a rapport. She was difficult to engage with, seeming to have a learning disability. Often she had her head in a glue bag and refused to give it up. Over the next few months the team linked her to a GP and regularly went with her to make sure she got her medication. She did not want anything to do with psychiatry or social services, so the team took the more active role, though a keyworker from a community mental health team stayed in the background. The team took her to the council's homeless department who put her in bed and breakfast, then a flat of her own. The team also introduced her to a day centre run by MIND, which she liked and attended daily on condition she abstain from solvent abuse on their premises. When Jane was offered a council flat, the team helped her with the practicalities: getting furniture, setting up the bills, liaising with the DSS etc. But after settling in, Jane became very lonely and invited in men who exploited her. She began poly-drug abusing and injecting substances. She took frequent overdoses and cut herself to express her unhappiness. She became well known to the department of psychological medicine at the John Radcliffe Hospital from her frequent short admissions. The Elmore Team became involved in mini case conferences with both the housing department and the health authority. They looked for other options for Jane who was clearly not managing independently, and likely to be evicted from her flat, because of complaints from neighbours. The flat was in a terrible state and it took two team members to give it a blitz clean. This was all before Jane went to The Knowl in Abingdon for a long period of respite care. It was an excellent move which got her away from her undesirable associates in Oxford and gave her a regular routine and structured activities.

Chapter five: Appendices

Bibliography

Jon Vagg (1986), *Support for Difficult to Place People in Oxford*, Oxford; Elmore Committee

Jon Vagg (1988), *Filling the Gaps*, Oxford; Elmore Committee

The early years of the Elmore team

Dr Peter Agulnik, a consultant psychiatrist who has been a member of the Elmore Committee since its earliest years writes:

In 1983 Oxfordshire Health Authority called a conference to discuss provision for 'difficult to place' people of all ages. A group of us who had attended the conference began to meet regularly. Pat Goodwin, who was a senior probation officer, and I approached Mrs Patricia Vereker who was chair of the Elmore Committee, as well as chair of the juvenile bench.

The Elmore Committee was founded by Robert Elmore, an academic, with an interest in social policy and later deputy chairman of the health authority. The Elmore Committee had started running a hostel for ex-offenders. Mrs Vereker took over from Robert Elmore as chair of the Elmore Committee. She was very interested in the idea of providing a service for 'difficult to place people'.

There were frequent concerns on the bench about the provision for mentally disordered people appearing before the courts. Mrs Vereker was a close friend of Lady Franks who was chair of the Oxford Bench. Both became 'champions' of what we were trying to do and set up a working party in 1984. This eventually became a sub-committee of the Elmore Committee.

The sub-committee employed Dr Jon Vagg to produce a report on the needs of the client group entitled *Support for Difficult to Place People in Oxford* (1986). The preface from the 1989 reprint of the Jon Vagg's report talks of the early beginnings of the Elmore Team: *"The Elmore Committee's community support team is a project resting on the report's research findings of Jon Vagg's report. The aim of the project was to demonstrate a new way of providing care in the community, by setting up a flexible team of peripatetic workers who would be in contact with 'difficult to place' people wherever they were. By drawing in other relevant agencies, the workers would provide support that is appropriate to the clients' needs."*

The conclusion, drawn from the research, was that support for 'difficult to place' people depended on bringing together the many agencies and services concerned with the clients. It became apparent that, since the research was undertaken an intricate network of inter-agency panels had been developed in the city. There was, in addition, an excellent primary health care clinic for patients with no fixed address, through which they could be referred to the appropriate health services. There was also increased direct support from the mental health services.

As a result of these developments it seemed that the existing agencies were better able to contain the 'difficult to place' in the short-term. However, the inter-agency 'network' had limited resources for continuing support to hostels or continuing packages of support to the clients to enable them to manage more successfully.

In May 1988 the committee received a grant from the then Department of Health and Social Security to set up an innovative pilot project with the general aim of helping mentally disordered people get better care in the community. This grant enabled the committee to set up the Elmore Community Support Team, now known as 'the Elmore Team'. The team would provide support for the 'difficult to place' group which appeared to be growing in number.

By adding to and using the resources of the existing network of statutory and voluntary provision it is hoped to increase the likelihood of these clients achieving some stability in their day care, accommodation and general quality of life. The Elmore Community Support Team became fully operative in January 1989.

Mission statement

The team's mission is to work with people whose needs are on the margins of agency-based provision in the healthcare, social care, accommodation or criminal justice systems. Agencies, either singly or within a network of care, regard these individuals as 'difficult to place' because their problems are multiple, chronic or presented in bizarre or disorderly ways. They need intervention if they are to make the best use of the services that agencies ordinarily provide. The Elmore Team believes it can do this effectively and efficiently by offering the help of a team with specialist experience of their problems, and working in an integrated way with both the individual client and agencies concerned, until the individual's needs can be absorbed into the agency's core functions. Any individuals presenting as 'difficult to place' in the City of Oxford are eligible for the services of the Elmore Team.

Statement of aims and objectives:

There follows an attempt to combine a formal statement of the aims evolving from the mission statement with sufficient illustrative material to make it clear how they apply in practice.

1 To **identify** accurately and speedily individuals who have multiple or chronic problems and/or who present them in bizarre or disorderly ways. (Such persons are defined in the mission statement as 'difficult to place'). They may have no current contact with the social, housing, penal or health services, or their problems may be so complex that they fall outside the ordinary resources of the agencies, even when working in collaboration

Clients come to the notice of the Elmore Team in a variety of ways but most are referred by staff in statutory or voluntary sector agencies, social services, the criminal justice system or the health services. Others come through self-referral or personal intermediaries.

Not all those referred will become clients. Preliminary assessment may suggest that a particular person might get better help elsewhere, for example, from a community mental health team.

2 To provide an **outreach** service for rough sleepers.

To identify, engage with and support individual rough sleepers to enable them to gain access to existing accommodation and community services and offer opportunities to move from their current lifestyle into a more settled way of life.

3 To **assess** the factors which, singly or by interacting, prevent individuals from using all the material, social and psychological resources which would ordinarily be available to them.

The Elmore Team places no predefined limits on the range of factors that might be relevant. Commonly, however, access to 'supplies' is restricted by intrinsic factors (mental or physical illness or disability) and extrinsic (social isolation, poverty, homelessness, offending behaviour, unemployment etc) or, most frequently, complex combinations of these factors.

4 To **formulate** appropriate responses to the assessed needs of each individual in such a way that the network of agencies can eventually resume their normal roles.

Careful processes of assessment, consultation, supervision, and recording are normal practice. For some difficult to place clients, services from other statutory or non-statutory agencies will enable them to stay in a stable position within the existing network. For others, a lengthy period of continuing care and support by the team is required.

For many clients, the task includes identifying suitable accommodation options and support in collaboration with housing providers.

5 To **provide** a wide and flexible range of services, both directly to the clients and also to the agencies.

There is no predefined limit on the type of casework which may be undertaken. Support services are offered to a wide spectrum of difficult to place clients eg. within the criminal justice and mental health systems, people with health problems, including HIV/AIDS, and others.

6 To **facilitate**, encourage and strengthen the inter-agency liaison at all levels.

Includes day-to-day work concerning individual clients, with staff of any relevant agency, and policy development with managers.

Consultancy concerning services for difficult to place clients is offered to agencies within Oxfordshire. The team also takes a lead role in co-ordinating the local network of services to homeless people.

7 To **monitor** and evaluate the work of the team, and to make available the outcomes as appropriate.

For example the annual report, including numerical data, is approved by the Elmore Committee and sent to service purchasers. The work of the team is often included in studies or pieces of research by other agencies or interested parties, both locally and nationally.

8 To **educate** and train people whose statutory or professional roles bring them into contact with people in need, on relevant issues using the experience and expertise of the Elmore Team.

Eg. providing fieldwork placements for DipSW students and trainee CPNs and through involvement in local training initiatives.

Job description: community support worker

Responsible to the Elmore Team manager.

Purpose and accountability

To provide community support to single adults with chronic, multiple problems who do not easily fit into existing range of service provision (termed 'difficult to place') and to provide outreach to rough sleepers. To work within an existing team of support workers whose job descriptions are identical, regardless of professional background. (Monday to Friday, 37.5 hours a week, flexible working hours with some early morning/evening work)

Service provision: 'Difficult to place' clients

1 To identify potential clients both through active outreach work in the community and through contacts with relevant agencies.
2 To assess client needs and plan initial course of action. If the client is not suitable for Elmore support, to refer on to other suitable agency or agencies.
3 To act as focal point for the client, building appropriate packages of care and guiding them back into mainstream service provision where possible. Such care packages may include:
   - forming trusting relationship with client and offering emotional support
   - assessing financial problems and offering relevant advice and information or active intervention where appropriate
   - enabling client to access suitable accommodation where possible and support client in maintaining such accommodation
   - encouraging client to make links with day care services
   - assisting client to make contact with medical services and keep appointments
   - be prepared to advocate for the client in all health care, social care, accommodation or judicial matters. To support client in any other feasible, practical way that will enable him/her to improve quality of life.
4 Be sensitive to the needs of any client from any part of the community.
5 Be responsible for individual clients as part of an allocated caseload.
6 Keep up to date with relevant legislation that might affect clients (including DSS benefits, housing, mental health and criminal justice).

In relation to outreach to rough sleepers

1 To identify, engage with and support individual rough sleepers to enable them to gain access to existing accommodation and community services and offer opportunities to move from their current lifestyle into a more settled way of life.

2 To link rough sleepers with resettlement workers where possible. If the rough sleeper is also 'difficult to place' this work can be undertaken by the Elmore Team.

Service provision: agencies

1 Understand the network of agencies available and keep such information up to date.
2 In conjunction with other members of the team act as an information/advice/consultancy service for other agencies, particularly focusing on their understanding of the needs of 'difficult to place' people.
3 In conjunction with other members of the team, be involved in training events for other agencies.
4 Encourage flexibility and co-operation at all levels with other agencies towards the needs of 'difficult to place' people.
5 Be sensitive to the restraints, boundaries and legislation that affect other agencies and their operation.
6 To liaise with other agencies and represent the team at relevant interagency meetings, with the agreement of the manager.

In relation to the team

1 To attend and participate in regular team meetings, team study days and supervision with the team manager.
2 Deputise for other team members as required.
3 Have an active role, with other members of the team, in the development of team policy and practice.
4 Undertake to follow all team policies and procedures, and assist in developing such policies and procedures as required, particularly in the area of health and safety at work.
5 To attend appropriate training courses with agreement of the manager.

In relation to administration

1 Keep case notes up to date and ensure that good written and verbal communication is maintained between relevant parties in relation to clients.
2 Undertake three-monthly written reviews on all current clients.
3 To record information for monitoring and evaluation purposes as requested.
4 To carry out, within reason, any other duties necessary to the smooth running of the project.

Community support worker - person specification

We consider that the following experience, skills and ability are desirable for this post:

Experience

1 A minimum of 12 months experience of working with people with mental health problems (in statutory or voluntary sector setting), plus one or more of these groups in the community: people with substance misuse problems; current or ex-offenders; people with accommodation problems such as homelessness/rough sleeping or difficulty maintaining stable accommodation; people with bizarre or challenging behaviour.
2 Experience of working independently and taking responsibility for your own workload.
3 Experience of working in a problem-solving context with a variety of statutory and voluntary agencies and professionals.

Skills and abilities

1 Ability to work flexibly towards creative solutions with clients who have seemingly intractable problems.
2 Ability to work holistically with clients, looking at all possible support needs, including benefits and other financial matters.
3 Ability to keep accurate casework records and maintain filing systems.
4 Ability to work effectively as part of a team.
5 Ability to build effective professional relationships with clients and work with clients in a non-patronising and respectful way.
6 Ability to set boundaries, to challenge appropriately, and to manage conflict constructively.

Knowledge and understanding

1 An understanding of the housing, welfare benefits systems and relevant mental health legislation.
2 An understanding of the causes of homelessness.

3 An understanding of the differing support needs of people of different sex, class, age, ethnic origin, sexuality, disability and HIV status.
4 An understanding of the issues faced by people with support needs, particularly those which might arise when dealing with clients in a community setting.
6 An understanding of the particular staff safety problems potentially faced when working with people in a community setting.

Attitudes

1 Commitment to provision of support with respect to different lifestyles and preference.
2 Willingness to attend regular training and share skills within the team.

Support worker competencies

1 In relation to client work

1.1 Assessment of client needs

The support worker must be able to demonstrate that he/she can assess client needs in the following manner:

- with imagination and creativity
- in a comprehensive and holistic fashion, endeavouring to cover all aspects of the client's current position
- planning realistic and attainable goals
- based on Elmore philosophy and culture
- as part of a continuous process
- with specific attention to risk assessment

1.2 Client contact

The support worker must be able to demonstrate the following attributes in relation to client work:

- judgement of when to be assertive or directive with clients (or other agencies)
- judgement of when to provide unconditional acceptance to client
- self awareness of own style and opinions and how they are impacting on the client (or other agencies)
- acceptance that some clients may not be able or willing to change, often for long periods of time
- thorough and sensible approach to following the Elmore Team health and safety policy

2 In relation to other agencies

2.1 Knowledge of local services

The support worker must be able to demonstrate the following in relation to knowledge of local services:

- proactive approach to exploring local services
- continuous updating of knowledge and active work to fill gaps in that knowledge
- ability to use local services creatively
- make constructive input to inter-agency meetings when required

2.2 Response to referrers

The support worker must be able to demonstrate the following in relation to referrers, even if the person referred does not appear to fit criteria:

- be accessible and flexible to requests for advice and information
- be prepared to use knowledge of local services
- be thorough in following up anything that arises from the referral

3 In relation to the team

3.1 Support to team

The support worker must be able to demonstrate the following in relation to the rest of the team:

- constructive contribution to team discussions
- flexible to needs of other team members (including covering work when possible/necessary)

3.2 Time management

The support worker must be able to demonstrate the following in relation to personal time-management:

- ability to cope with fluctuations in case load
- ability to prioritise work to meet Elmore aims and objectives
- responsiveness to needs of the team balanced with the needs of the client
- be respectful of appointments - both within the team and with clients

4. In relation to administration

4.1 Case notes

The support worker must be able to demonstrate that he/she is keeping case notes in the following manner:

- up to date
- mindful of responsibility to team and clients
- clear, accurate and thorough
- with respect to both clients, colleagues and other agencies involved
- with thought given to potential readers and the use they will wish to make of the notes

4.2 General procedures

The support worker must be able to demonstrate that he/she is aware of and following Elmore policies and procedures at all times. This will involve active input into the formation and review of policies and procedures.

Confidentiality policy

The Elmore Team undertakes to treat all information about any individual with utmost respect and, where appropriate, strict confidentiality.

It is essential for Elmore workers to have as complete a picture as possible of every aspect of their client's life if work is to be thorough and safe. Information gathered is treated as confidential within Elmore.

Elmore workers will seek the permission of the client wherever possible to talk to other agencies or parties. However, in cases where a client is at risk either to themselves or others, information will be shared appropriately with or without the permission of the client. However, if any client is found or suspected to be dealing controlled substances or smoking cannabis/opiates on Elmore Team premises this will immediately be reported to the relevant authorities.

The Elmore Team recognises that it is essential that all those responsible for supporting a client are bound by the same rules of confidentiality in order to enable proper sharing of information. Careful consideration is to be given by the Elmore worker that this is the case before information is shared.

At no time may Elmore workers discuss clients in an informal setting.

Written information on clients in the Elmore offices (including that which is stored on computer) is kept locked up outside office hours. All confidential written information which is disposed of is shredded.

Guidelines to obtaining client permission to obtain/share information

1 In principle, the Elmore worker should seek to discuss with the client at the earliest opportunity the potential need to obtain/share information from/with other agencies or individuals. Specific instances should be cited if possible. The support worker should also outline occasions when circumstances might necessitate information being shared or obtained without the client's explicit permission. The outcome of this discussion should be recorded clearly in the case notes.

2 Circumstances that might necessitate information being shared or obtained without the client's permission are outlined in the information protocol document, Section five and six. In summary, these include:

- when the client is felt to pose a risk either to self or others. This would include instances when a support worker, or other person connected to the client, would be at risk if the client knew that information had been shared.
- when there is a legal requirement to disclose information, for example, regarding serious crime/or child/adult protection.
- when progress towards meeting the needs of clients with otherwise seemingly intractable problems cannot be made without further information. This should not take place without detailed discussion with colleagues and an agreement reached that this is the only way forward.

Draft: the joint protocol on sharing information between all agencies providing care to people posing a risk to others or at risk to themselves in the community

1 Background

The Department of Health, in many publications[3], has identified the need for all agencies working with people at risk in the community, to have agreed and clear inter-agency communication systems. This protocol aims to meet this need in Oxfordshire by providing a framework within which decisions can be made regarding the sharing of information between agencies.

Service providers and users agree that the existing informal networks generally result in good practice in this area, but also that a clear mutually understood protocol, widely disseminated, can be a valuable contribution in assisting services to meet increasing pressures.

2 Present situation

Currently, the sharing of information works as well as it does because of relationships of trust built up between individual practitioners. An inter-agency protocol will formalise existing good practice, whilst recognising the boundaries around the autonomy of each agency.

It is recognised that:

2.1 ***the individual practitioner*** must be free to make the decision whether to disclose or withhold information, working to his/her agency's confidentiality policy, and being aware that he/she may be called upon to justify that decision;

2.2 ***each agency*** is responsible for their own policies on confidentiality and the supporting of their staff in making their professional judgements;

2.3 ***partnerships*** between agencies may have developed arrangements or formal protocols relating to the sharing of information between them.

3 Benefits of sharing information

Many agencies contribute to the care of people at risk in the community, each providing a particular expertise. Co-operation between professionals can lead to:

3.1 a closer match of the care plan to the needs of the client leading to a better compliance and outcome

3.2 decision sharing can lead to agencies jointly managing the risk plan, and hence greater risk taking to the benefit of the client

3.3 more confident accountability in agencies, being able to give clear reasons for particular decisions

3.4 increased understanding of different agencies' perspectives and, gradually, development of a common language which will improve communication

3.5 identification of gaps in provision, and highlight the need for special resources to central government.

4 Key principles

Good practice in joint working among agencies requires the sharing of information which is:

4.1 imperative where there is deemed to be risk to the physical safety of any person

4.2 ideally given with the permission of the client

4.3 clear and understood by the receiving professional

4.4 relevant and sufficient for the task in hand

4.5 factual, or clearly stated if by hearsay

4.6 takes full cognisance of confidentiality issues and is recorded as confidential and having been shared under this protocol

4.7 prepared to learn lessons from situations as they arise.

5 When information must be shared

5.1 When there is a legal requirement on statutory agencies eg. child (or adult) protection

5.2 Workers must alert those at risk as well as other relevant workers/agencies, when an assessment is made that an individual poses a grave risk to the physical safety of any of the following:

- family (especially children)
- carers
- members of the public
- staff of statutory and voluntary agencies

[3] *Building Bridges: Suicide Prevention: A Place in Mind* and both the Jonathan Newby and Darren Carr inquiries.

6 When consideration *must* be given to sharing the information

6.1 When the client is threatening to self-harm

6.2 To aid decision-making when care planning with the client, especially in matching provision to need, when the information shared will be in the light of the objectives of the agency.

7. How information will be shared

The signatories will include the following in their procedures:

7.1 client consent to be duly recorded preferably with the client's signature

7.2 client to be encouraged by key worker to share his/her information with others involved in his/her care as appropriate

7.3 client to be informed of circumstances when non-consent will be over-ridden, unless to do so would increase the levels of risk around the client

7.4 agencies practice will include procedures to ensure maximum confidentiality in sharing of information by electronics means

7.5 quality recording, which is essential if information to be shared is to be guaranteed as factual and clear

7.6 training of all staff in professionally sound theory and practice

7.7 confirmation that confidentiality must not stand in the way of effective risk management

7.8 a philosophy that collaboration must not be hindered by agency or professional boundaries, but that conditions of confidentiality and privileged information pertain at all times.

8. Monitoring the protocol

The monitoring of the use of the protocol by the protocol steering group will identify learning points for future practice. This would link in with the 'near miss' or serious incident review process currently being developed.

Statistics

Referrals to Elmore Team by source

	1997	1998	1999/2000
Total	**144**	**131**	**144**
Health	35	30	50
Housing	42	17	18
Probation/ criminal justice	30	32	24
Social services	20	23	16
Other	10	29	36

Source of referrals – detailed breakdown

	1997	1998	1999/2000
Total	**144**	**131**	**144**
Self	2	8	15
Friend	2	5	6
Other	6	16	10
Daycentre, etc	-	-	9
Hostel	22	9	3
Housing	20	8	14
Chilton/drug & alcohol	6	5	4
Barnes Unit	4	7	7
GP	6	7	15
CMHTs	26	11	20
Police/court	7	11	9
Probation	23	21	15
Social services	20	23	17

Outcome of referrals to Elmore Team in 1999/2000

Accepted as client	54%
Short term work	13%
Advice information	23%
Brief intervention	10%

Clients by gender

	1999/2000
Total	**139**
Male	102
Female	37

Clients by age

18-24	15%
25-44	55%
45-64	25%
Over 64	5%

Ethnic origin of clients in 1999/2000

(Total 139)	
Afro-Caribbean	5%
Asian	4%
Other	1%
White European	1%
Irish	2%
White UK	87%

Known needs of clients

	1999/2000
Total	**144**
Housing	103
Dual diagnosis	84
Alcohol	57
Drugs	60
Substance misuse	117
Financial diff.	54
Learning diff.	27
Offending	58
Self harm	40
Physical health	37
Mental health	127

Client mental health problems in 1999/2000

(Total139)	
Anxiety/depression	38%
Unknown	2%
Dementia	1%
Drug induced	2%
Other diagnosis	6%
Brain damage	6%
Schizophrenia	22%
Personality disorder	23%

Client accommodation 1999/2000

(Total 144)	
Housing association tenancy	17%
Council tenancy	25%
Council (temporary)	12%
Other	6%
Family	4%
Short term hostel	4%
Own home	4%
Friends	4%
Direct access shelter	5%
Private rented	8%
Sleeping rough	11%

National Homeless Alliance
5-15 Cromer Street, London WC1H 8LS
tel 020 7713 2840/2849
fax 020 7713 2848
email NHA@home-all.org.uk

Elmore Team
23 Park End Street
Oxford OX1 1HU
tel 01865 200 130
fax 01865 246 039
email staff@elmoreteam.fsnet.co.uk

Elmore
Community Services

elmorecommunityservices.org.uk

Elmore Community Services are a registered Charity (1090616)