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A Little Local Difficulty:

The Management of Difficult-to-Place People in Oxford

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It is well known that homeless populations contain many individuals with mental disorders, personality disorders, behavioural eccentricities, and track records of offending (e.g., Archard, 1979; Brandon, Wells, Francis, & Ramsay, 1980; Central, London Outreach Team, 1984; Stewart, 1975). And it is often pointed out that among these overlapping populations of homeless and mentally disordered people, a large group repeatedly falls through or between the frameworks of care that are provided by both official agencies and voluntary organisations. If or when such people appear before the courts, the options available to judges or magistrates are often regarded as unsatisfactory—not least by the judges or magistrates themselves. These observations are as true in the city of Oxford, in the United Kingdom, as they would be anywhere else; a large number of local reports and other documents, by local health authorities, magistrates, and voluntary bodies have noted the problem (e.g., Elmore Committee, 1985; Oxford Regional Health Authority, 1976; Oxford Regional Hospital Board, 1971). This group of people, the hardest to help and the most troublesome to manage, who do not fit neatly into the administrative pigeonholes of the official caring agencies, who tend therefore to rely extensively on the services of charitable bodies (including night shelters and hostels), and yet who frequently disrupt or destroy the attempts made to help them, have come locally to be called the "difficult to place."

"Difficult to place" (abbreviated in this paper as DTP) is not a term formally used in any agency. It was coined in 1982, when several Oxford interagency working parties were considering various groups for whom, it was thought, there was inadequate psychiatric and social services care, and poor options for accommodation. DTP began as a concept of exclusion, describing people whose major characteristic was that they did not "fit" the remits even of these rather specialized interagency working parties. Consequently a "DTP Sub-

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The research was commissioned and overseen by the Elmore Committee, 23 Park End Street, Oxford OX1 1HU, UK. The Committee is a voluntary body with charitable status, which since 1968, has managed accommodation for homeless exoffenders. In 1984 a working party of the Committee took up and developed the work of the "DTP Subgroup" mentioned in the text. The research on which this paper is based was funded under the "Joint Finance" scheme by Oxfordshire Social Services Department and Oxfordshire Health Authority. Opinions expressed in this paper are the author's own and responsibility for any errors are his.

Group" was set up to consider this disparate set of people. In practice, many of those described as DTP were mentally ill or mentally disturbed (and often not amenable to treatment), often recidivist offenders (though usually only committing relatively minor offences), and almost all homeless in the sense that they move along a sequence of hostels, down-market guest houses, prisons, and so on. They were the "difficult cases" that a range of agencies, including the psychiatric, probation and social services, and a range of voluntary sector hostels and day centres, felt unable to help or, in some instances, to control.

The term reflects potential solutions, or the lack of them, as much as behavioural or other problems. People were described as DTP when their behaviour, perhaps bizarre or disruptive, led workers dealing with them to feel that they could not be contained in the facilities they were using—hostel, psychiatric ward or day centre, for example. They were also said to be DTP when it became clear that they were falling through the "net" of statutory provision; falling between agency definitions of their tasks, or needing types of support which could only be provided through an interagency approach. This paper, based on a 1985–1986 research project (Vagg, 1987) has two aims. First, it describes why, in the view of those who deal with them, individuals are DTP. Second, taking the view that the "difficulty" is not simply to do with the individual but also with the resources of various agencies and the relations between them, it examines the problems that have appeared in attempting to help, manage, and ultimately control such individuals.

Difficult to Place People

The research on the "DTP problem" was fairly rough and ready. Thirteen facilities in Oxford city were asked to contribute information on those they considered "difficult" so that a register of individuals was built up. Ultimately 138 individuals were described as DTP by one or more facilities (for the list of facilities see Table 1). Agency staff were also interviewed to discover how difficult people were managed. In addition, the researcher attended a number of meetings of various interagency liaison groups for the same purpose. Those considered DTP were not themselves interviewed formally, though the researcher was able to mix with them freely in the various agency settings.

The 138 people described as DTP were almost all male and aged in their thirties or forties. One third (34%) had a psychiatric diagnosis at the time of the survey, while four individuals were described as suffering personality disorders. At least 72% had a criminal record while a further 8% had been involved in offending behaviour (e.g., thefts from other hostel residents) though without being reported to the police for this. The majority of offences mentioned were of theft, though there were three cases of arson and one each of burglary and rape. The figures for both psychiatric problems and offending are almost certainly underestimates. If there was no local history of psychiatric involvement and no local knowledge of prior psychiatric history outside the city we did not attempt further checks. This was equally true for offending; and in addition we did not take account of offences of drunkenness for which individuals were cautioned rather than prosecuted (Oxford police operate a

TABLE 1
Distribution of DTP Individuals Across Agencies

Facility	Noted DTP by Facility		DTP Known to Facility		In Care of Facility at Time of Survey[a]		
		% of DTP Group		% of DTP Group		% of DTP Group	% of Those Using Facility
Psychiatric Facilities:							
Acute service	6	(4)	22	(16)	10	(7)	(13)
Rehabilitation service	28	(20)	47	(34)	19	(14)	(9)
Detoxification unit	4	(3)	7	(5)	0	–	–
Probation service:							
Casework teams	4	(3)	14	(10)	n/a	n/a	n/a
NFA day centre	15	(11)	42	(30)	7	(5)	(18)
Hostel	6	(4)	8	(6)	1	(1)	(6)
Social services:	10	(7)	22	(16)	11	(8)	(2)
Voluntary provision:							
Simon House (hostel)	35	(25)	47	(34)	24	(17)	(26)
Church Housing (hostel)	6	(4)	19	(14)	2	(1)	(2)
Night Shelter (emergency accomm)	37	(27)	72	(52)	37	(27)	(62)
Night Cellar (emergency accomm)	3	(2)	5	(4)	2	(1)	(8)
The Mill (psychiatric daycare)	4	(3)	8	(6)	2	(1)	(4)
UB40 (unemployed drop-in centre)	2	(1)	14	(10)	2	(1)	(1)

[a]The figures in this column have been calculated as far as possible using the estimated number of regular users of different facilities. With psychiatric rehabilitation facilities account has been taken of day-patients as well as inpatients. With psychiatric acute services, the number of beds in the wards surveyed was used. For social services, the figure was calculated from the Client Index, although this contained a proportion of inactive cases, which artificially reduce the percentage given. For voluntary agencies, staff estimates of the number of regular users were obtained and so far as possible checked against night-lists or other documentation. n/a indicates figures not available.

scheme under which those found "drunk and incapable" are only prosecuted following their third arrest in any eight week period—otherwise simply being cautioned).

Information on family background and even the date of first contact between individuals and agencies proved elusive or, often, contradictory. Voluntary agencies do not usually keep permanent files on their clients, and staff turnover is frequently high. The date of first contact with a given individual was often estimated as, for example, "before any of us started work here, but none of us have been here more than two years." Where individuals were named by two or more agencies, there were frequent conflicts in the data provided by each, even over such matters as whether or not the individual was in contact with his or her family. Of those for whom we obtained unequivocal data, the majority were single but remained in contact with their family—though the term "contact" encompassed not only visits to relatives, but also anything from attacks on relatives to writing a few letters a year. For the 51% for whom we could establish a place of origin, there was a 50/50 split between those born in Oxford or Oxfordshire, and those born elsewhere in the United Kingdom or abroad.

The questionnaire to agency staff concerning those they described as DTP asked whether or not they saw individuals as having any of 18 specific problems (e.g., in obtaining welfare benefits) or problematic attributes (e.g., aggressive or abusive behaviour). The two most common factors mentioned (see Table 2) were bizarre or eccentric behaviour and difficulty in maintaining accommodation, each mentioned in over half the cases. Descriptions of bizarre and eccentric behaviour included "staying up all night, very high, talking to himself"; wearing items such as blankets in public; repeatedly attempting to phone fictional individuals; purchasing rabbits' heads from a butcher and keeping them in a hostel room; and violent mood swings. Living at one address for a lengthy period may well have been difficult for many of the DTP, not least because of the extent to which landlords would be prepared to accept such behaviours. However, the "spread" of problems was wide. Four separate types of problem was the modal average, but 26% were said to have 7 or more problems, while at the other end of the scale 14% had only 1 problem or none of the types of problems we had precoded. However, in the 23 cases where staff from 2 or more agencies answered questions on the same individual, there was no case of complete agreement between the agencies as to what problems the person faced—indeed, in 1 case, the 2 agencies concerned identified 12 problems between them but only 1 was mentioned by both agencies.

Table 1 indicates that three facilities—a night shelter, a hostel, and the psychiatric rehabilitation sector—were much more likely than other agencies to consider people DTP. Many of these people were also known to the probation service's "No Fixed Abode" (NFA) day centre, which, however, did not consider them difficult. The majority of the DTP (84%) were so considered by only one facility, though over two thirds were known to three or more facilities, in the sense that they had stayed with, been referred to, or made use of them at some time. This pattern, together with the poor agreement between agencies about the problems posed by certain individuals, suggests two things. First, and perhaps obviously, given our initial definition of DTP, the descrip-

TABLE 2
The Incidence of Assessments of Problems Among the DTP Group

Type of Problem	Persons with Problem	
	Number	% DTP Group
Bizarre/eccentric behaviour	78	57
Maintaining accommodation	70	51
Aggressive behaviour	65	47
Problem-drinking episodes	60	44
Handling personal monies	56	41
Finding accommodation	56	41
Abusive behaviour	48	35
Offending (behaviour, *not* criminal record)	46	33
Severely attention-seeking	43	31
Personal hygiene	39	28
Obtaining welfare benefits	31	23
Obtaining psychiatric attention	28	20
Use of illegal drugs	24	17
Fire risk	22	16
Abuse of prescribed drugs	21	15
Obtaining medical attention	20	15
Obtaining social services attention	11	8
Solvent abuse	11	8
None of the problems coded	2	1
TOTAL Persons	138	

tion of individuals as DTP was largely a function of the kinds of resources that particular agencies were able to command, and of the agencies' definitions of their functions. At the time of the research, the emergency night shelter was going through a "bad patch." It had only 3 staff on duty on most nights, frequently with around 40 people sleeping there. It was the place to which people would go when they had been thrown out of other accommodation, perhaps for bizarre or violent behaviour. It was thus particularly liable, and vulnerable, to disruption[1]. The NFA day centre, staffed with trained workers and probation assistants, was able to absorb a substantial amount of aggressive and bizarre behaviour. Second, and also perhaps obviously implicit in the definition of the term, from a management point of view the DTP could be said to comprise at least two groups: the majority, who posed problems for only one agency (though many were thought to be "unreferrable" by the agency dealing with them), and a minority who passed back and forth between two or more agencies and who were considered DTP by each agency—though often with each agency citing different reasons for thinking of any one person as DTP.

[1]Shortly before the research ended, substantial changes took place in the management of the shelter and Oxford City Council made substantial alterations and improvements to its premises. The difficulties mentioned in the text were thus resolved.

Patterns of Care

These points raise two questions about the extent and nature of interagency action. Why were so many individuals being cared for in ways that the caretakers felt were inadequate, given the wide range of provision, particularly in the voluntary sector, available in Oxford city? And what was the pattern of interagency action that resulted in an admittedly small group of people moving repeatedly and relatively quickly between a range of agencies and being considered DTP by many of them?

The answer to the first question is, simply, that identifying an individual's "problems" does not automatically mean that "solutions" exist. Many of the DTP remained where they were because no realistic avenue for better help could be found. This can be illustrated briefly with reference to the "needs" of the DTP group, as assessed by the workers involved with them. Interestingly, workers in statutory agencies, in particular, seemed to conceive of needs in terms of the kinds of organizational arrangements that they thought would be able to support the individual. The needs were related to the individuals' problems as perceived by the agencies. As illustrated above, different agencies had widely differing views on the problems presented by any one individual; views that reflected their respective mandates and resources. The needs that were cited varied in the same way and, moreover, tended to be expressed in terms of the "ideal type of organisation" to which the worker would like to be able to refer the DTP person.

Thus, the range of needs mentioned included—the list is illustrative rather than complete—5 people needing hostels with much higher staffing levels than current funding arrangements allow, 13 who could cope in independent accommodation provided that they received frequent visits from agency staff, 10 thought to need psychiatric residential care (these assessments not restricted to those with diagnosed psychiatric conditions), and 14 in need of specific training programmes. But, as one worker in a voluntary agency commented, the needs of these people did not remain static but changed, often week by week, between, for example, the need for strict externally supplied limits and rules through to the relative freedom of independent accommodation. And some 19 people were thought to be beyond realistic possibilities of aid, for reasons including a lack of motivation to accept it through to a history of refusing or sabotaging offers of help. Given these conditions, it was perhaps not surprising that 85 of the 138 DTP had not been the subject of any interagency action in the 6 months prior to the survey.

If the majority were DTP for one agency and there was little prospect of finding better ways of helping them or coping with them, what of the rest? The kinds of cross-agency arrangements made for those who were considered DTP by several agencies seemed to revolve around three models: referral, expulsions, and shared care. To some extent these shaded into each other in the ways described below.

"Referral" usually meant that a worker in one agency would write or telephone to a worker elsewhere to ask whether the latter would "take on" the case. In some cases, it was hoped that the outcome would be a "shared care" arrangement, say between a day centre and a hostel. In others, the intention

was to move the individual out of one facility and into another—that is, serial rather than concurrent involvement of agencies. We traced 74 referrals, relating to 53 individuals, in the 6 months prior to our survey. These figures include referrals to the two night shelters, referrals not strictly necessary since both operated an "open door" policy. But they almost certainly underreport the actual number of referrals because we were unable to ask agencies which did *not* consider individuals as DTP, whether *they* had referred the person elsewhere. Two thirds of these referrals originated from statutory agencies, and were fairly evenly divided between referrals to other parts of the same organization (e.g., from one ward to another in a mental hospital), to other statutory agencies, and to voluntary or private care organizations (principally private nursing homes). The remaining third originated from voluntary organizations and were divided equally between referrals to statutory bodies and to other voluntary agencies. Half (37) had been accepted, while the outcomes of 14 were either unknown or pending. How successful the "accepted" referrals were is difficult to determine, since a miscellany of other factors arose; individuals refusing to go to a new placement, being arrested prior to the move, or the referral being judged "successful" by staff even though the individual had since returned to the referring agency. Perhaps ironically, many of the referrals that were not accepted were intra- rather than interagency referrals.

Another pattern of movement around the network of agencies is illustrated by the use of "bars," usually from voluntary sector facilities, for violation of institutional rules. These were, usually, for a specific period of between about 1 and 4 weeks. Those falling foul of the rules of the hostels found themselves, in the main, in the night shelter. Thus there was a constant turnover of individuals between the hostels and the shelter. In a few cases this had been extended in scope, and had become a semiformalized system of management of the individual, designed to land the "problem" in only one institution at a time and to give the staff in the other time to "recover." In such cases, each institution in turn would bar the person from their premises. But this shared understanding and operation of bars usually only occurred between voluntary agencies and the probation NFA day centre. However, the same effect could be achieved unilaterally; some people had at various times been barred from using certain (residential) psychiatric facilities and had perforce ended up in the night shelter, so that the shelter was in one sense a kind of "sin bin" for people who did not behave elsewhere.

For some of the DTP, the arrangements between institutions had been semiformalized into agreements about "shared care." Almost a quarter of the DTP (23%) had at some time been recipients of this form of care, and over half these arrangements involved the psychiatric sector together with some other body (or bodies). The spread of agencies involved was quite wide; the type of care almost always involved either a periodic shuttle between two places offering accommodation, or an agreement that one agency would provide accommodation and the other day care.

These kinds of interagency activities were, for some of the DTP, probably less to do with "finding appropriate care" than with control—though this can perhaps be seen in one sense as a kind of care. There were 22 people who appeared to be moving round "the system" at some speed. One, admittedly the

most extreme case, was referred 11 times in an 18-month period during which he lived in 8 separate establishments. In November 1984 he was staying in one night shelter but was banned from it following an attack on staff. The other shelter housed him until, in early 1985, he was given a probation order for an offence and required to reside in a probation hostel. This quickly broke down and he was admitted to a psychiatric ward for observation. He was discharged in mid-1985, subsequently living in another hostel, using the NFA day centre and continuing to receive medication for his psychiatric condition. After being evicted from this hostel he moved to another, and then on to a lodging house. Early 1986 saw him in bed and breakfast accommodation but by April 1986 he was back in a night shelter and beginning to use a local unemployment drop-in day centre.

The Problems of Interagency Action

Interviews with workers revealed four problems that dogged interagency action. First, the manner of interagency communication itself created difficulty. This was not the result of a *lack* of communication. In addition to all the formal and statutory arrangements for interagency planning and so forth, there were two monthly meetings open to workers from all agencies; one was hosted by the probation service, and the other met at the offices of the City Housing Department and was chaired by the director of one of the voluntary hostels. Many workers visited or telephoned each other frequently; and when a doctor's surgery was set up (in a portacabin) for the use of night shelter residents, its administrator, who had previously been a "referral worker" at one of the hostels, became the hub of an informal communication network among workers from the various agencies. Yet most of this activity—the setting up of the meetings, and discussion on individual cases—was initiated from the "bottom up" rather than the "top down." Those attending tended to be the coordinators of voluntary agencies and staff, rather than managers, of statutory ones. On the statutory side, those involved in discussions thus did not have the authority to commit agency resources to individual clients.

Second was the issue of confidentiality. Typically, workers in the voluntary sector were under no obligation of confidentiality—though the opinions they offered were their own and usually the only file kept on an individual would be a record of rent payments. The legislation and internal codes under which statutory agencies operated all contained provisions governing the confidentiality of information on clients. There were some instances in which voluntary sector workers claimed they had been put physically at risk because critical information about individuals referred to them had been withheld. In one case, a hostel was assured that an individual posed no fire risk and discovered that he had a record of fire-raising only after he had set a small fire. On the other hand, one set of interagency meetings almost collapsed when statutory sector workers complained that information given to the meeting in confidence was being minuted and widely circulated.

Third, staff in the voluntary sector frequently insisted that while they were prepared to accept people into day centres and accommodation when asked to do so by statutory agencies (usually the psychiatric services were mentioned),

referrals back to the statutory agency when the person became uncontrollable or deteriorated in other ways often failed. In part, this also had to do with an enduring difference between the psychiatric sector and almost every other agency about the extent to which there should be some "psychiatrically oriented management" of cases judged psychiatrically untreatable. It was often felt by, for example, voluntary sector workers that the training of psychiatric staff fitted them for a caring role here even if treatment was not possible.

Fourth, even where "shared care" was set up and operated well for some time, voluntary sector workers complained that the level of involvement from the (usually statutory) agency sharing the care was often too little and subject to breakdown. Social services in particular were singled out for criticism here, with claims that initial promises to visit the individual regularly slipped quickly into a pattern of visits only following specific requests; that the relevant case-workers went on holiday without making covering arrangements, and that they were in any event very difficult to contact. It was often asserted that individuals had "blown up" or "gone into crisis" over relatively minor problems that would have been easily solved if the relevant worker could have been contacted in time.

Summary and Conclusions

So far we have outlined the cloud rather than the silver lining; and it is true, for example, that instances of "shared care that worked" could be found. But in general, the situation appeared to be that a small number of people posed difficult problems, often linked with aggression, for a range of agencies. It was perhaps ironic that many of the most difficult problems were picked up by the voluntary sector, which might be characterized as "the only place left to go" when statutory agencies decided that individuals had become too difficult to cope with. Interagency action was certainly possible, and attempted; but structural problems in its organization and differences of perspective between psychiatric and other agencies led to problems of implementation and sometimes to bad feelings. Part of the problem seemed to be that agency workers, in identifying individuals' needs, talked about the kinds of organizations that would be able to cope with the individuals. This limited their horizons. Individual "packages" of measures, perhaps in the form of "shared care," seemed eminently suited to the situation, provided they could be flexible enough to cope with quickly changing needs and provided that many of the relatively trivial details were systematically attended to—such as ensuring that everyone involved in a "package" knew the others' holiday dates. But this would not, by itself, be enough. Developments on these lines would also require movement in two other directions: on the one hand, to institute "top down" measures in the sense that the heads of agencies agree on the ground rules within which they could happen, and on the other, the delegation of more authority to rank-and-file workers to accept or refer cases. In some ways, this is a question of rethinking the forms of accountability within our statutory agencies. There will probably always be, as we have noted, a "rump" of people who cannot be helped perhaps because they do not wish to be; but the possibilities of more effective help and support for the rest were there to be grasped.

Postscript

It is rare to be able to report on a problem and its solution in the same paper. But since the research project on the DTP was completed, events have moved ahead, at first slowly, but latterly with great speed.

More care does not equal better care. A wide range of agencies were already involved with the DTP; the problems were those of inflexibility and lack of coordination between agencies, coupled with differences of perspective resulting from the different mandates and aims of the various agencies. In terms of practical action, the desired outcomes were: individualised "packages" of care, coordinated between agencies; agreements between heads of agencies on the ground rules for cooperation; and improvements in referral procedures. The Elmore Committee, which oversaw the original research project, envisaged that these aims could be achieved through setting up a small team of workers whose role would be to support DTP people either directly or, more probably, by supporting workers in other agencies in their dealings with such people. The practical problems in obtaining support and funding for such a team, the way in which it was ultimately set up, and its early experiences, are documented elsewhere (Vagg, 1989a, 1989b). Suffice it to say that funding was made available by the Department of Health and Social Services of the British Government (as it then was[2]); cooperation locally was forthcoming; and the "Elmore Community Support Team" opened its doors to referrals on 3 January 1989. The fact of its existence is not only a monument to a small group of dedicated people, but also and equally importantly shows what can be achieved through interagency cooperation.

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[2]In late 1988 the Department of Health and Social Services was split into a Department of Health and a Department of Social Services.