Canterbury Community Shelter

campaign4change

A list of key campaign issues and their impact on those engaging with CatchingLives from 1 December 2016 to 28 February 2017

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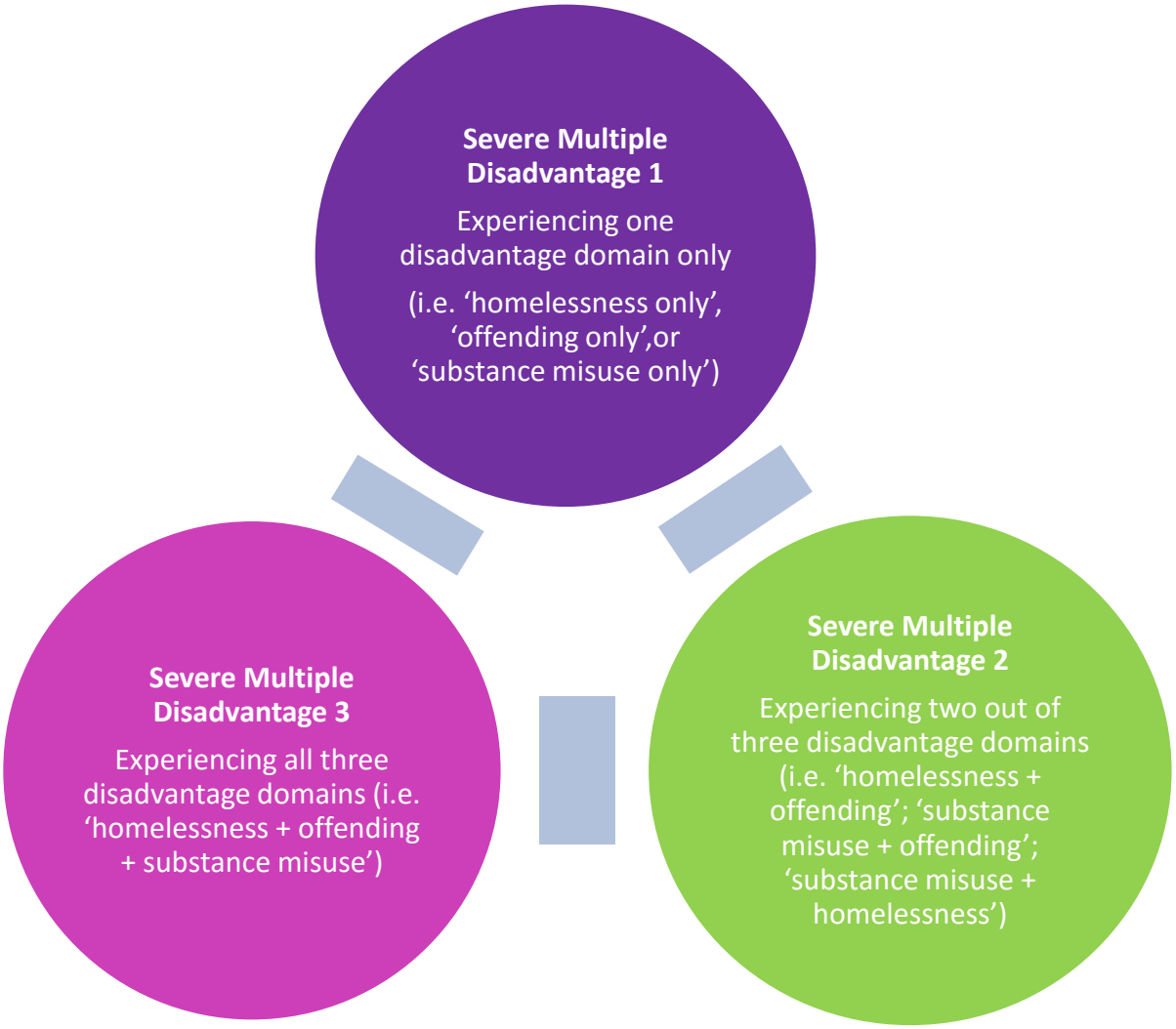
Introduction

The campaign data collected at the Canterbury Community Shelter has been compiled for your perusal, alongisde some statistics. The clients are anonymised.

One very clear outcome from this data is that we are right to prioritise our **#BreakTheCycle** campaign as this is an issue that has effected just over **10%** of the clients who stayed in the shelter.

It is important to understand the demographic of clients who stayed in the shelter, and the Canterbury Community Shelter Report 2016-2017 gives these statistics. It is equally important to highlight the impact of Severe Multiple Disadvantage on clients who accessed the shelter.

What is Severe Multiple Disadvantage?



In the ***Hard Edges: Mapping Severe and Multiple Disadvantage in England*** Report compiled by Lankelly Chase; the national statistics were published with regard to Severe Multiple Disadvantage.

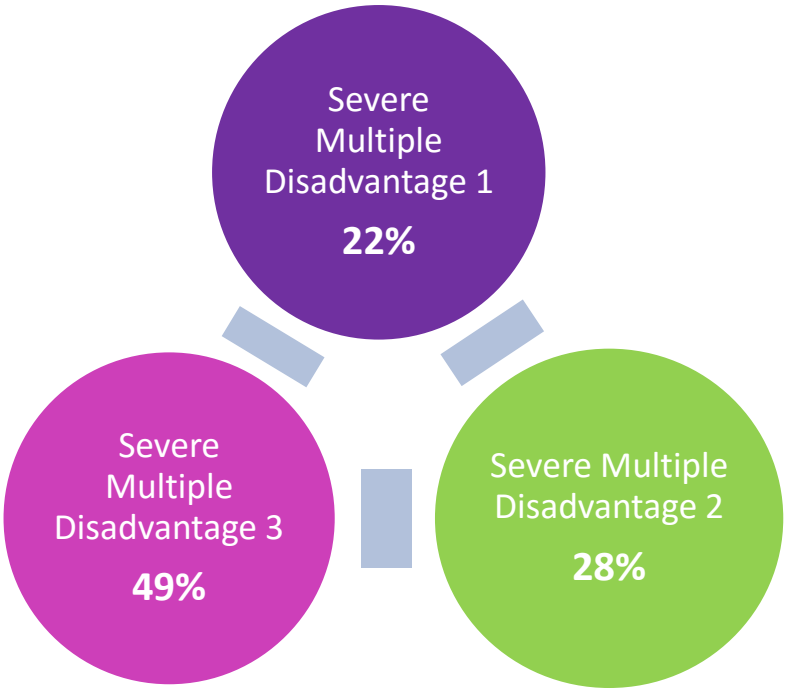
The main findings were as follows:

- each year, over a quarter of a million people in England have contact with at least two out of three of the homelessness, substance misuse and/or criminal justice systems,

and at least 58,000 people have contact with all three;

- SMD, is distinguishable from other forms of social disadvantage because of the degree of stigma and dislocation from societal norms that these intersecting experiences represent;
- people affected by this form of SMD are predominantly white men, aged 25–44, with long-term histories of economic and social marginalisation and, in most cases, childhood trauma of various kinds;
- in addition to general background poverty, it seems to be in the realms of (very difficult) family relationships and (very poor) educational experience that we can find the most important early roots of SMD
- in practice the distribution of SMD cases varies widely across the country, and is heavily concentrated in Northern cities and some seaside towns and central London boroughs. However, all local authorities contain some people facing SMD;
- the quality of life reported by people facing SMD is much worse than that reported by many other low income and vulnerable people, especially with regard to their mental health and sense of social isolation;
- SMD creates a significant cost for the rest of society, particularly with respect to disproportionate use of certain public services;
- there are some encouraging short-term improvements reported by services working with people who face SMD, but progress is weaker amongst those with the most complex problems.

With this in mind, the number of clients who accessed the Canterbury Community Shelter had the following levels of SMD:



Out of those guests with SMD3

33%

Disclosed that they spent time in Local Authority Care and experienced childhood trauma.

The social as well as economic disadvantage associated with sustained poverty was often alighted upon in explaining its relationship with SMD in the report.

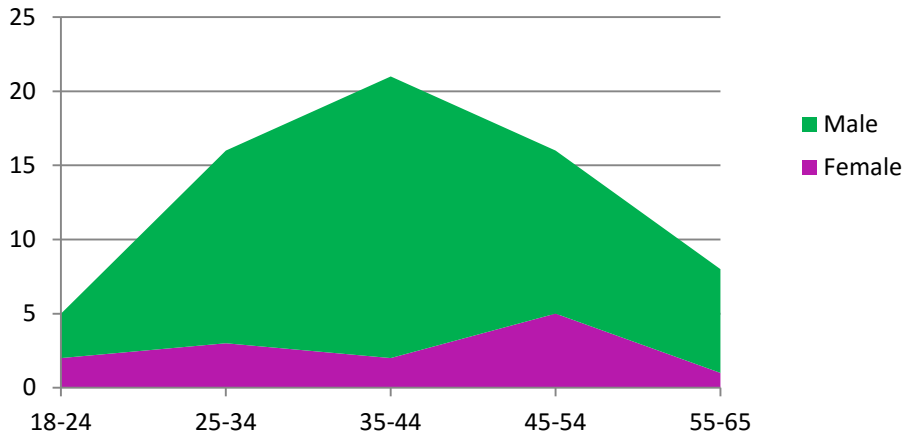
At the same time, the importance of 'complex trauma' associated with childhood abuse (sexual, physical, emotional) or neglect (physical, emotional) was widely identified as increasing the likelihood of poorer children facing SMD later in life.

Please remember that this statistic only comes from the data collected from the Canterbury Community Shelter guests who accessed the accommodation. If this principle was applied to the whole of Catching Lives data I am sure that it would provide enough evidence to support any funding application.

100%

of guests facing SMD3 have a mental health condition that has been diagnosed by a professional

Age Range of Guests facing SMD



Severe Multiple Disadvantage creates significant costs for public services, in addition to the human costs for individuals and their families. The corollary of this is: that investment in more effective interventions might bring about significant savings or 'offsets' which might outweigh, or at least mitigate, the costs of investment.

Evidence and Impact Statements Collected (1 December 2016 and 28 February 2017)

Prison Release to Street Homelessness

Cause of Problem

Client released from prison 17 October 2016 to street homeless. Currently on Bail for allleged sexual assault on a female. Client's previous prison sentence was 04/2016 - 17/10/16 - for burglary.

Impact on Client

Client had to engage with Canterbury Community Shelter, he is diagnosed with ADHD and Oppositional Defiant Disorder - symptoms of oppositional defiant disorder may include: frequent temper tantrums, excessive arguments with adults, refusal to comply with adult requests, always questioning rules; refusal to follow rules, behavior intended to annoy or upset others, including adults, blaming others for one's own misbehaviors or mistakes.

Client has a history of drug use and is currently not using, however, there is concern if his housing situation does not improve he may start using again, or commit further crime.

Client needs help with his mental health conditions to break the cycle of prison, release to street homelessness and prison.

Prison Release to Street Homelessness

Cause of Problem

Client was sent to HMP Bronzefield in December 2016 for a shoplifting offence, and released to street homelessness on 9/2/17. She spent that night, and the others since, rough sleeping.

Impact on Client

When talking about her recent release from MHM Bronzefield to street homelessness, in her words she feels "pissed off that she cannot just go home to be left alone and stay out of trouble". She states that it is when she becomes bored or upset she takes more of her medication than she should, or she begins to drink, and this is when she gets into trouble. She also wishes she could come off her methadone script, which she has been on for 20 years, but is scared to, and unable to without secure accommodation.

She has a long history of problematic heroin use, having first used when 14 years old. She is currently on a 55ml methadone prescription. She states she wishes she could come off this prescription as she has been on for over 20 years; however she feels she is unable to without stable accommodation. It is largely due to this long-term heroin that she has had a large number of prison sentences for shoplifting and thefts, undertaken to fund her dependency. Client states she has lost count of how many times she has been to prison, but knows it's at least 18 times, meaning a considerable portion of her adult life has been spent in prison, and has stated she sometimes feels better able to cope inside prison than 'on the outside', indicating a degree of institutionalisation.

She also wishes she could be sent to rehabilitation for this heroin use but has been told she cannot due to not engaging with support services in past. She has a long history of mental health issues and has been diagnosed with schizophrenia, has depression, experiences anxiety and panic attacks. Her daily medication currently consists of diazepam (10mg), mirtazapine (14mg) and quetiapine (300mg).

The medication she is on places her in a very vulnerable position whilst rough sleeping as it makes her feel very drowsy. Furthermore she states that when she is distressed situations, such as her current state of rough sleeping, that she often takes more than the prescribed dosage and is concerned that she will be unable to look after her medication whilst living on the street. She was also sectioned and spent 2 nights in St Martin's hospital, Canterbury in December 2016 after being picked up by police for her own safety due to heavy amphetamine use. She has self-harmed in the past and states she currently feels suicidal. She has also had a traumatic childhood, spending a number of years in care, stating she was abused physically, sexually and emotionally by her foster father. This abuse has continued into her adult life, and she has experienced domestic violence from multiple relationships, with one such relationship resulting in 5 years of physical and emotional abuse. She has in the past entered such relationships in an attempt to remove herself from living on the streets; however this has resulted in her putting herself in an equally vulnerable position.

Prison Release to Street Homelessness

Cause of Problem

Client released from Elmley Prison to Street Homelessness 16/12/16 to street homelessness, he was furnished with a list of winter night shelters and a letter from NACRO stating that they had made a homelessness application on his behalf with Canterbury City Council, but no indication as to what to do with this information. Client served 45 days of a 90 day sentence. Clients past offences have included burglary, drug dealing (heroin), assault, theft, he is a prolific offender and classed as PPO.

Impact on Client

Client has always committed drug related/fuelled crime and feels that if he can keep clean he will stop offending. Client has expressed that he often feels anxious, he also disclosed that he needs to deal with why he uses substances to self medicate. He wants to deal with the cause this time in order to help his rehabilitation. He has reached an age where he just needs a break in order to re-embrace family life and be there for his daughter and grandchildren as well as his wife. Client has been referred to Canterbury Community Shelter for accommodation.

Prison Release to Street Homelessness

Cause of Problem

Client released from prison to street homelessness (HMP Elmley) Friday 25/11/16 after a 42 day sentence for shoplifting. Client currently on 30ml methadone script - engaging with Turning Point.

Impact on Client

Client diagnosed with ADHD as adult around a year ago in Elmley Prison. Client suffers with anxiety and depression and although client used to takes mirtazapine and stated he was on Anti Psychotics and mood stabilisers - he states he is currently not on medication.. Talking to GP about possible disasociative identity disorder and paranoia. Client had signs of self harm in the form of cuts to the wrists, although this was not discussed.

Client has had multiple prison sentences for Section 4 public order offences, GBH, ABH, burglary, robbery. Cannot remember dates, believes last sentence was about a year ago. Client stated that the poice tried to apply MAPPA related to GBH and ABH but it didn't go through.

Client was in recovery - was a heavy user of crack, heroin, cannabis in the past, he was also dealing during this time. He had not used for three years, but has relapsed. Client was a heavy drinker in the past, but not to the level of physical dependency. Client states other rough sleepers in Maidstone are causing him issues (violence against him).

Client is in a cycle of shoplifting and substance misuse. Relapse risk is seriously increased by his homelessness, along with the risk of a return to shoplifting. This can be prevented by a joint working system which provides accommodation and continued support to those leaving prison. A dedicated housing and substance misuse service within the hospital would help to prevent releasing people to homelessness where repeated overdose is more likely when people are discharged to street homelessness.

Prison Release to Street Homelessness

Cause of Problem

Client has been a heroin and crack user on and off for 25 years, he was clean for seven years but has severe jealousy when in relationships, diagnosed with Othello Syndrome, after his last relationship ended he relapsed. He has been in prison on and off since the age of 16 and this is when he started taking heroin.

Client feels that his family was incredibly dysfunctional, as children he and his siblings were scared of their father, he disclosed that he witnessed domestic violence and felt the home was unhappy and stressful.

Client states that he loved living the lifestyle that wasn't orthadox, he felt that heroin was his secret and he revelled in it. This drug made him happy when high so he used that to self medicate his sadness about his chilldhood.

Client's father committed suicide when client was 21, client's mother left his father after 22 years of marriage and his father killed himself. This has had a very profound effect on the client emotionally, he still feels very sad.

After his father's suicide client started using crack on top of his heroin.

Client was released from prison on 13 March 2017 after being recalled from a 20 months sentence, he served two weeks. Client was in Elmley Prison and whilst in Elmley client was taking methadone. Client was released and went directly to his heroin dealer as he had been released to street homelessness and he felt that his addiction wasn't addressed upon release, "there is no aftercare". Client states that his housing wasn’t mentioned whilst in prison, he says that the prison are suffering massive cut backs.

Impact on Client

Client has immediately started heavily using heroin and crack upon his release from prison to street homelessness. Client is shoplifting to fund his habit.

Client states that if he had accommodation upon release he feels that he may have kept the motivation to stop using. He states that when taking heroin at night it makes him feel warm - it's his mental and physical and emotional painkiller. He can't move forward and make his life one he doesn't

want to escape everyday until he has a room with a bed and then he can engage and get a job, he has a CSCS Card and is desperate to leave this self abusive behaviour behind.

Release from prison with no money (to street homelessness)

Cause of Problem

Client released after serving 1 month on remand in Elmley, to street homelessness. No discharge grant was given and since release he has tried to complete a 'rapid reclaim' for ESA. Still not in place (needs to send a new sick note) so he has no income at all. Adding to this stressful situation, Kent Probation gave him a travel warrant for an appointment on 'Thursday 21st March' which is an incorrect date, leaving him confused as to when appointment was. We phoned on his behalf and they realised this was a mistake (should have read Thursday 23rd) so they sent another one by post.

Impact on Client

Client is released to street homeless with no money and was left to sort this (claiming benefits) by himself, whilst also sorting other appointments (such as with Turning Point, probation (due to mix up). He has become very frustrated due to having to make repeated calls to DWP to sort his ESA and having no money to get by.

Release from prison to street homeless & discharged from hospital to street homeless

Cause of Problem

Client was given a 60 day prison sentence for a breach of his probation terms which he is on for various shoplifting offences. He served 30 days of this sentence and was released to street homelessness. In the week after his release he overdosed on spice and was discharged to street homelessness. Client suffers from epilepsy and has Hepatitiis C, both of which he is medicated for.

Impact on Client

Client was very upset at the situation he found himself in. He was very tearful and under a lot of stress as his mother is seriously ill and may not live for very long. He was desperate to get off the streets and into Canterbury Community Shelter but struggled to meet the cut off times in order to access the shelter. His substance and alcohol use increased and he was in a very chaotic situation. He was trying to manage attending probation in Sittingbourne and visit his mother to care for her whilst this was all happenning and felt unable to cope with all of this.

Mental Health Hospital Discharge to Street Homelessness

Cause of Problem

Referred to Canterbury Community Shelter by North East Kent Crisis and Resolution Home Treatment Team - St Martins Hospital, Canterbury 136 Team. The Crisis Team can support him, if he has a fixed abode for a period.

Impact on Client

Client will receive no support from the Crisis Team as he is homeless. He engaged with Catching Lives and Canterbury Community Shelter instead. When a client is in crisis that is when the support should be received, homelessness is a crisis!

Hospital Discharge to Street Homelessness

Cause of Problem

Client had an operation at Kent and Canterbury Hospital on 28/12/16 in order to drill a hole in his nose to improve the airways owing to asthma. Client was open about his situation and explained that he was homeless, this was not addressed by staff and client was discharged on 29/12/16 after the operation to recover on the streets.

Impact on Client

Client was on the street and scared for his health; he wasn't able to follow any recovery advice on the street. He had to take the offer of sofa surfing on a crack/heroin dealer's couch, which did not help his mental health and made him feel vulnerable. Client feels that the outcome of the operation has been hindered by his experience, and that the effect has not been as good as expected for him. Client is still street homeless currently.

Hospital Discharge to Street Homelessness

Cause of Problem

Client has had pancreatitis and was hospitalised six weeks ago in Kent, Medway and Gillingham. Client was discharged to street homelessness on 07 November 2016.

Impact on Client

Client was effectively discharged to a tent in the woods, where recovery would have most definitely been hindered. Client had to rely on the Canterbury Community Shelter when he should have been accommodated to recover properly.

Hospital Discharge to Street Homelessness

Cause of Problem

15/03/17- Client had a toe amputated (second one he has had amputated) and was kept on Quex ward at QEQM. During his stay he also had an alcohol detox.

20/3/17- Project Worker spoke to a nurse on the ward who stated he needed home care, including daily dressing changes and the administration of his 3 weeks of antibiotics so they were reluctant to discharge him to street homelessness. PW spoke to Canterbury Council housing officer to explain the client had been in a very bad way for last week or so before going into QEQM (heavy drinking, and reports from other homeless clients he had not moved from same spot for days) and that we were concerned that a return to the streets would lead to a return to heavy drinking (with lowered tolerance level due to the detox and added problems due to being on antibiotics, meaning he may have side-effects such as drowsiness, making him more vulnerable, or he may stop taking them, making a subsequent infection likely to occur, resulting in him going back to hospital, worst case, dying.

The housing officer informed PW that they had a phone interview booked with client for 28/3/17. However the client was discharged to NFA on evening of 24/3/17 with no money to get from Margate back to Canterbury (and his foot strapped up, making it very difficult for him to walk). I informed the council who suggested he attend to make a homelessness application in person. The client has

longstanding issues with infections (see notes below) and now has had two toes amputated. He also has shown strong signs of depression since we've known him (observed by our mental health team) but no known diagnosis.

16/02/15- Client had infected feet and was in hospital over the weekend. He was given antibiotics but still in a lot of pain.

17/06/2015- Given antibiotics for another infection and is going to the GP twice a week to have dressings changed.

11/08/2015- Client has had his toe fully amputated and it will take up to 3 months to heal.

03/09/15- Client's foot has become infected. He has seen a doctor and is on antibiotics.

23/06/2016- Client prescribed naproxen, flucloaxcillin (penicillin -type) and Metronidazole (treatment for bacterial infections) due to infected foot ulcer. 24/11/16- Client's doctor wrote - "worsening right sole, offensive smelling ulcer since June- getting bigger and painful. Hepatitis B carrier. Amputated right big toe, and all other toes appear deformed."

Impact on Client

Client's health is at risk, with high chance of developing a new infection whilst living on the streets.

Hospital Discharge to Street Homelessness

Cause of Problem

Client had a large abscess in groin. He was seen in hospital and told by a doctor that he would need to stay as an inpatient for treatment pending an ultrasound scan. Another doctor told him that unfortunately there were no beds available and so was discharged to return the following day for a scan, despite being in significant pain and unable to walk properly. Client managed to get a lift back from the Kent & Canterbury Hospital to Canterbury Open Centre but once at the center was unable to stand.

Project Worker phoned the hospital and the NHS Direct 111 number to try and advocate that client was too ill to be on the streets and that we could not manage his health needs in the rolling winter shelter we were operating. NHS Direct informed us that the only advice they could give was to call an ambulance if his condition worsened. As there was no other option obvious, we managed to get him to the church hall which was operating as the shelter for that night. During the evening at the church hall the clients abscess burst and he began vomiting. Staff called 999 and requested an ambulance. The call handler informed staff that they were very busy and could not say when an ambulance might arrive. They could not even give assurance that an ambulance would be sent. Two volunteers from the church shelter took the client to the hospital in a car.

When they arrived at the hospital the member of staff at the front desk of the Urgent Care Centre was initially reluctant to admit the client as he had already been seen at the hospital that day until a senior nurse intervened. He was discharged from Kent & Canterbury Hospital on 03/01/2017 after having surgery on his abscess and returned to the Canterbury Community Shelter.

Client was then given a Non-Priority Decision by Canterbury City Council on 02/02/17 despite the previous hospital admissions, surgery and being treated for a chest infection. Client was then

subsequently admitted to hospital again later in the month, to be discharged again on the 17/02/17 after contracting CAP (Community Acquired Pneumonia. A new approach was made after his final hospital discharge to Canterbury City Council and they housed the client in temporary accommodation, pending their inquiry into his case. He has now been diagnosed with cancer and has had to have his elderly sick dog put down. He is still in temporary accommodation as of 04/04/17.

Impact on Client

Male, 56 years old, White British and in receipt of benefits. Homeless for 3-4 years after living in Canterbury Local Link for approx 10 years. History of heroin addiction. In recovery for approx 10 years before becoming homeless again.

Client was in significant pain and was confused by the discharge. He was very frustrated and did not see the point in my trying to get him admitted before the abscess burst. Not being admitted in the first instance made the situation much worse and when the abscess burst he was in considerable distress.

Inappropriate use of Canterbury Community Shelter by Probation

Cause of Problem

Client was referred to Canterbury Community Shelter by Folkestone Churches Winter Shelter owing to lack of bed spaces.

Client presented himself at Canterbury Open Centre (our homeless day center) with a travel ticket paid for by Probation, despite concerns over referral.

On the registration form it was noted that the client was a schedule one offender. This prompted Jon Limebury to investigate in order to assess the risk to the client/staff/volunteers/guests etc.

JL expressed his concerns to client's probation officer. He confirmed that Canterbury Community Shelter is a rolling model which uses 7 different venues - one for each night of the week; and that he had informed Heather at your office that one of those venues has an early years school on its premises.

He also confirmed with that due to the above and the Post-Sentence Supervision Period, Section 11, sub section v. "Reside permanently at an address approved by your supervisor and obtain the prior permission of the supervisor for any stay of one or more nights at a different address", he did not consider that the winter shelter was appropriate.

JL stated that it is his understanding that, following the client's residence at St. Catherine's Approved Premises, he should have moved into a permanent residence. JL asked why this did not happen and why he has been sent to Canterbury Community Shelter.

Email Response from [redacted] *- Probation Officer.*

Client was indeed at the approved premises ([redacted]*) when first released and was unfortunately recalled. He was then released on 12 December 2016 to no fixed abode. He has sought help from the local authority but has been assessed as non-priority. He has been referred to*

supported accommodation but he has been assessed as unsuitable. Having recently left prison he has limited money and little experience of being homeless. The hope is that he will access support, with a deposit so that he can get privately rented accommodation but at present that is not an option either. Hence why we are now seeking support from the night shelters.

As discussed on the telephone (with Jon Limebury), the information that you needed confirming is below:

Although his post sentence supervision states he needs to permanently reside at an address, I have authorised him staying at night shelters, particularly because the alternative is for him to be sleeping outdoors.

He is currently assessed as high risk of harm to children and a medium risk of further offending. This assessment is based on his offending behaviour and the fact he has just recently been released from prison. Client is in contact with myself and ViSOR most days to keep us updated on where he is staying.

I can confirm that his restrictions state that he cannot have unsupervised contact with children nor can he have access to the internet.

In regards to those centres which may have children attend in the morning, I can either make it clear to the client that he is to leave the premises earlier in the morning. Alternatively, if he is assessed as unsuitable for those shelters then can he please be considered for the others.

Client handed in an offensive weapon to Catching Lives staff by his own volition. He carried it because he was fearful for his own safety. He had never been homeless before.

Probation should not be using winter night shelters to accommodate those who have residential bail conditions.

Impact on Client

Client was fearful for his safety. He was very anxious and had to leave the day center on more than two occasions because children were on the premises. There were several verbal altercations with other guests as client lacked the social skills to communicate with others; he often said very rude things to other guests which led to him being bullied.

Incorrect Information from police causes street homelessness to continue

Cause of Problem

Client is street homeless; an application was made to Stonham House, in Wincheap Road, Canterbury in October 2016. Part of the process for Stonham is to request a police check on potential new tenants. When client's police check came back it stated:

A list of the specific information to be disclosed is listed here (not the information itself which must be recorded separately). Information to be disclosed:

Client is known for many violent offences. The most recent offence was in 2015 which was assault. There have been no offences reported to police since 2015. Client is also known for burglary, theft, criminal damage and wounding however these are from many years ago.

Client is on the Sex Offenders register.

I confirm that full consideration has been given and that I am satisfied the information listed above may be disclosed. This information is provided to you solely for the purpose set out within your request and must not be used for any other purpose without my prior and express written authority.

Signed: PCSO [redacted] *Date: 14/11/2016*

This is incorrect information, specifically with regards to client having committed sexual offences.

Impact on Client

When client was told of this false information, client felt gob smacked, he couldn't believe that this was happening. It has totally consumed him, and he turned to drugs over the weekend period in order to block out any kind of feeling. Client had abstained from drug taking for some time before this. He felt victimised and was worried for his personal safety if people found out. This also kept the client from securing accommodation from October 2016 to date as he was turned down based on this incorrect information being passed to the housing provider. Client feels terrible still being in the same situation through no fault of his own. He has children and desperately wants to start having contact again, so he feels that this has had a very negative impact on his family life. Client was a victim of sexual abuse as a child and is completely disgusted that he could be accused of such a thing. He felt physically sick and couldn't eat properly for a week. Client is now getting support from a solicitor in order to pursue this outrageous case; he is also receiving help from Catching Lives.

Lack of Support for Client with Complex Needs

Cause of Problem

Client has been diagnosed with ADHD and Personality Disorder. Client has had numerous outbursts when she feels mistreated. She is fleeing an abusive relationship, her ex-partner pinned her to the floor, smashed a plate in her face and held his hands over her mouth and face.

Client owed a duty of care by Social Services, but cannot approach Canterbury City Council as she has been barred from there for previous bad behaviour. She has a Porchlight worker. Client feels she would need support with maintaining accommodation.

Client states that her high support needs were too much for Porchlight and she was evicted. This accommodation was temporary.

Client did not stay engaged with the service unfortunately.

Impact on Client

Client has been given no support to deal with her mental health issues or the fact that she is fleeing domestic abuse. She was angry and upset that her abusive partner had got her into her situation. If client was supported properly she may well be in a refuge, which is a safe environment in which she could grow and be supported. Client could have felt discriminated against owing to her mental health issues, being told that she was evicted owing to her support needs being too high; and not being signposted to any further help must have compounded her anxiety. It is unknown as to whether she is safe, but she is definitely vulnerable.

Lack of Support in Supported Accommodation

Cause of Problem

Client was engaging with Catching Lives before moving into a Canterbury Local Link property, and he recently came in to ask our advice. Client had been in supported accommodation and part of his move on process was to move into Canterbury Local Link.

Client's Employment Support Allowance has stopped and he put in a Univeral Credit claim. He also states that Canterbury Local Link are 'angry that the housing element of Universal Credit will be going to him and not directly to them so have 'made it part of his tenancy agreement that he ensures this is changed' (we have not seen a tenancy agreement for this client). We have requested this happens with DWP but it is likely that UC will say that they cannot do this until he has arrears, client hasn't been seen for an update.

Impact on Client

Client believes he has dyslexia, and he has referred him to agency that can help determine this, he struggles with reading and completing forms (and is anxious about making phone calls on his own as he struggles to write down all the info he needs to remember).

Client states that Canterbury Local Link offer no support with the forms/phone calls etc, apart from changing his tenancy agreement to cover themselves, which has frustrated him.

Outcomes

Prison Release to Street Homelessness

This evidence is fresh and can now be used to highlight our **#BreakTheCycle** campaign in press releases, radio interviews and publication for the public. This evidence will reframe the "ex-offender" to the community by providing back stories that give insight to why this path has been taken, and how severe multiple disadvantage should be a priority need.

Hospital Discharge to Street Homelessness

This evidence will be passed to Marie Royal from Canterbury City Council, she has been liaising with Simon Cook (Head of the Council) since he took our previous evidence in this regards. It is important that the Local Authority see this as a priority issue that needs addressing now.

Inappropriate use of Canterbury Community Shelter by Probation

It is recommended that the Canterbury Community Shelter offers training with regard to completing registration, and on suitability of referrals.

Incorrect Information from police causes street homelessness to continue

This situation is being dealt with by the client's solicitor; who has been representing him from the age of 12. Client is still street homeless.

Lack of Support for Client with Complex Needs

It is recommended that on meeting clients such as these, an Adult Protection form is completed. Client had recently fled domestic abuse and is vulnerable, add to this the fact that she is street homeless and has disengaged. At least social services and the police would be made aware of her situation.

Lack of Support in Supported Accommodation

We are continuing to collect evidence on this issue, however, we feel we have enough to share with Lora McCourt at Canterbury City Council. She has assured our General Manager that she is looking into management agreements with organisations such as Canterbury Local Link, therefore it is imperative that she be privy to our evidence and impact reports.

Conclusion

Homelessness often follows on from contact with non-housing services such as mental health, substance misuse, criminal justice and social services. Despite this, housing agencies and homeless support services are often expected to take primary responsibility for dealing with this population, even though local authority housing officers have much less support and training than professionals in other sectors.

Necessary changes include earlier identification of and intervention with the key traumas likely to mark transitions into homelessness and SMD. At the other end of the cycle, men over 30 with substance/alcohol use and anxiety/ depression issues are especially neglected and require psychologically informed support to deal adequately with acute mental stress.

This report advocates support that enables professionals to learn from each other, to develop 'communities of practice' and to strengthen their co-ordination and 'personal assistant' role. A key role of the service offered to individuals, who are often isolated and overly dependent on services, is to promote positive social networks and relationships.

The more complex a person's needs, the more likely they are to fall through the gaps in the services society. The obstacles to effective service delivery are

- inter-personal;
- organisational and cultural; and
- structural.

Inter-personal factors involve both the behaviour of clients facing SMD, the professionals providing services and the relationship between the two. The stigma attached to some disadvantages such as homelessness and mental health issues can result in stereotyping and negative attitudes towards clients. These problems may be compounded by problematic behaviour, such as aggression or distressing behaviour, including self-harm.

Traumatic early experiences are found to be common among this population and may account for such behaviours as well as a general distrust of authority. Service providers and professionals are urged to be aware not to reinforce such negative outlooks or low self-esteem. However, it can also be argued that equivalent awareness is needed of difficulties experienced by service providers and the anxieties and frustrations of staff. The range of behaviours frontline workers may face include overdependency, excessive demands, emotional manipulation and self-destructive conduct. To prevent demoralisation and feelings of inadequacy, staff must be equipped with a framework for multiplicity that prepares and empowers them to deal with the most challenging clients; as they are at Catching Lives.

Several barriers are also identified concerning organisational and professional culture. Divisions between different care and service professions lie at the heart of many of these. Different professional models of care are likely to produce divergent interpretations of SMD, in terms the factor identified as the primary cause or driver of others, as well as the different approaches to the measurement of problems and outcomes. Workers may often experience a conflict between care and coercion in achieving desired outcomes. The need to balance these imperatives requires adequate guidance and support structures.

Finally, service design and delivery may not be suited to the nature of the clients themselves. For example, long and complex forms are given to people with literacy problems and personal identification is often required of people living chaotic lives. Services and care planning must therefore be designed with people facing SMD at the forefront, with user involvement as a key means of identifying and reducing barriers.

Structural factors largely stem from problems with funding and commissioning, in particular the single issue approach, whereby resources are allocated and distributed according to the component problems without adequate links to other disadvantages. More joint needs assessments are recommended, as well as a greater recognition that rigid funding can be a barrier both to joint commissioning and to innovation in service development.

Limited resources can cause problems beyond waiting lists and high case loads. By raising the thresholds required for access to services, adults who face SMD may end up with little or no help because their needs fail to meet the relevant level of severity despite the acute nature of their combined problems. A similar outcome may occur as a result of legal barriers.

While there is a statutory obligation to house those with 'priority need', those who are deemed 'intentionally homeless' are likely to be excluded, even though the apparently voluntary loss of accommodation can only truly be understood in the context of wider factors.

Without fundamental change adults with SMD will continue to be costly to the system, accessing expensive crisis services rather than structured support through mainstream services. Breaks and delays in care, difficulty navigating systems and duplication all harm professional/client relationships, discouraging engagement and preventing the high quality frontline services necessary to help this group.

It is evident that Canterbury Community Shelter has been the crisis service used in our area by probation and the hospitals; should the funding for next year be based on "community practice"? Partnership working/funding is imperative for the shelter to go from strength to strength. With more funding there could be even more intensive, on-going work carried out on behalf of those most vulnerable in our community.

A central data source with tiered access may be the way forward to improve community practice. It is something that was discussed at length at the Multi Agency Campaign Forum. This would promote the community practice theory, collaboration and not duplication of services.