Appendix

Housing Overview & Scrutiny Committee Report

Estate and Tenancy Management – Roles and Responsibilities

Case Study One

LH is a single person household - resident in a high-rise property. She approached her TMO requesting a move to alternative accommodation.

She expressed suicidal thoughts and explained that she had previously been prescribed medication and CBT following admission through A&E some years ago and felt some of these thoughts returning due to feeling isolated in her accommodation. She felt this would be resolved by moving closer to family and friends elsewhere in the borough.

She had recently lost her job and also had significant current and former rent arrears, as well as other priority debts with council tax, utility companies and short-term lenders. This was causing her significant stress and anxiety.

The TMO convened a multi-agency meeting with the following;

- Council tax
- Financial inclusion
- Housing safeguarding,
- Social worker
- Allocations

This allowed us to have a single view of her debt, consider further steps to provide a financial plan, the ability to review her history to establish present risk and formulate an action plan to link her into primary health care services and mental health support services and agencies.

What we did

- Referrals were made to StepChange, a debt advice service, to manage her household finances and form sustainable agreements with her debtors.
- Sustainable payment plans were agreed for her rent arrears and council tax debt
- She was given welfare benefits advice to enable her to maximise her household income
- An immediate risk assessment was carried out and she was rated as a low risk of self-harm.
- A support plan was put in place to enable referrals for a mental health assessment through primary health care routes
- The TMO carried out regular check-ins and acted as a point of contact for her – and continued to link her into other services as her situation developed

The outcomes were:

- Her debt reduced to a sustainable level and she felt for the first time in years that she had a plan for the future.
- She linked in with mental health services via her GP and, after a short wait, was accepted for further talking therapy, as she did not want to accept prescribed medication.
- She enrolled to volunteer with a local charity – this helped her gain confidence and she is now also looking to retrain and return to employment
- She feels more secure and less isolated in her current property and no longer wishes to move

Case Study Two

Mr H has paranoid schizophrenia – he has been open to ASC for many years, has a CPN and a history of being admitted under section when he is unwell.
He lived in a 1 bedroom bungalow amongst a complex of other bungalows at the centre of a general needs social housing estate.

He has a history of self-neglect, damaging property, hoarding behaviour, unsanitary behaviour by going to the toilet in the street after he had blocked his drains. He had been deemed as having capacity and was discharged from hospital back into his bungalow after it had been cleaned and cleared – to the cost of £25k, shared amongst services.

On return his behaviour was initially acceptable and he was accepting support but this deteriorated and his behaviour was impacting on immediate neighbours and the wider community who lived in the area and those who travelled through on foot. This behaviour was anti-social and potentially in breach of public order criminal thresholds.

The standard approach would have dictated that we focus on enforcement as the primary tool in dealing with this – this could have meant eviction and making Mr H homeless. However, due to his health and vulnerability, Thurrock Council would have had to have offered him services and accommodation to alleviate his homelessness.

We set up a multi-agency team consisting of;

- ASB
- Police
- Adult-Social Care
- NHS mental health
- Homelessness

The primary goal was to get Mr H to move to a more suitable, supported housing setting where he would be provided with the 24/7 access to services that would enable him to remain independent and living in a residential, rather than a clinical, setting.

What we did

- Arranged for daily visits to the property and site to inspect and resolve and immediate issues
- Daily caretaking site clean and clearance
- Set up regular contact with neighbours and a single point of contact for any concerns to be raised
- Weekly multi-disciplinary meetings were held throughout the duration of the interventions
- Joint work with NHS psychiatric teams to ensure that relevant information was considered.

We did retain the option of legal enforcement as an option – this was a fall back position to deal with worst case scenario and to ultimately protect the community.

The outcomes were

- Through persistent engagement from social work and community psychiatric teams, and intensive housing management to deal with the impacts of behaviour, we were able to work with MR H to persuade him to be discharged into a supported housing setting after a short stay in hospital.

Ultimately, this provided the best outcome for Mr H and also was quicker, more cost effective and less disruptive for the community.