Expert Citizens CIC

City of Stoke-on-Trent

Ministry of Housing, Communities & Local Government

COMMUNITY FUND

Changing Futures Stoke-on-Trent

Case Study:

When Housing Depends on Funded Care: The Impact of Support Contingent Accommodation Offer

Overview

David is a man in his fifties living alone in a council flat. Although he is technically housed, his living situation is unstable, unsafe, and deteriorating. Long-standing alcohol dependence, fluctuating mental health, and chronic environmental stressors combine to create a complex, high-risk safeguarding picture. Multiple agencies recognise that David likely has unmet care and support needs, yet structural barriers and his own trauma-shaped behaviours make assessment and intervention extremely difficult to achieve.

1. Background and Presenting Issues

Alcohol dependence and mental health David has a long history of alcohol dependence, with periods of severe anxiety, low mood, and disorganised thinking. His mental health presentation is highly variable and closely linked to alcohol use, external stressors, and episodes of grief or loss. He experiences rapid shifts in mood and cognition, making engagement unpredictable.

Living environment His council flat is in significant disrepair. Housing enforcement action is already in place due to concerns about cleanliness, damage, and the impact on neighbouring properties. The poor condition of his home both reflects and exacerbates his mental health difficulties. Environmental hazards—clutter, damage, hygiene issues—contribute to a cycle of crisis that services struggle to interrupt.

Community safety and safeguarding David frequently reports assaults or threatening incidents in the community. Some reports appear unfounded or inconsistent, often made when he is intoxicated or distressed. This creates a dual-risk safeguarding profile:

- He is vulnerable to exploitation, aggression, and harm.
- He also displays behaviours that can be threatening, unpredictable, or difficult for others to manage.

This duality complicates risk assessment and response planning.

2. Engagement Challenges

Communication and behaviour David's communication is chaotic and inconsistent. He may become verbally aggressive, withdraw from contact, or refuse entry to professionals. His willingness to engage fluctuates dramatically depending on alcohol use, mood, and perceived threat.

Service engagement

- **Alcohol treatment teams** struggle because his contact is almost entirely crisis-driven. He reaches out when intoxicated or frightened but disengages when sober or when structured support is offered.
- **Expert Citizens CIC** face similar challenges: he becomes overwhelmed or hostile when discussing support options, making sustained engagement difficult.
- **Social care teams** repeatedly attempt Care Act assessments, but aggression, avoidance, and inconsistent engagement lead to postponements or abandoned visits.

Professionals are left waiting for brief, unpredictable windows of stability that rarely last long enough to complete statutory processes.

3. Recent Deterioration

A significant decline followed the death of one of his three cats. His pets are central to his emotional stability, and the loss triggered intense grief, isolation, and increased alcohol use. He became more withdrawn, less able to manage daily tasks, and more distressed about the condition of his home. This deterioration heightened concerns about:

- Self-neglect
- Emotional wellbeing
- Environmental risk
- Sustainability of his tenancy

The grief episode illustrates how fragile his coping mechanisms are and how quickly his situation can escalate.

4. Systemic Barriers and Delayed Assessment

Despite clear indicators of unmet care and support needs, the system requires structured engagement, assessment, and consent before meaningful intervention can begin. David's trauma-shaped behaviours—avoidance, aggression, inconsistent communication—make these steps extremely difficult.

Key barriers include:

- **Assessment dependency on engagement**: statutory processes rely on cooperation that David cannot reliably provide.
- **Risk escalation during delays**: environmental hazards worsen, alcohol use increases, and safeguarding concerns multiply.
- **Fragmented multi-agency response**: each service sees part of the picture, but no single agency can progress without assessment.
- **Crisis-driven contact**: opportunities for engagement occur only during distress, intoxication, or fear—times when assessment is least feasible.

The result is a prolonged limbo: professionals can see that his needs are increasing, but the system is not designed to intervene assertively when engagement is inconsistent.

5. Multi-Agency Complexity

David's case sits at the intersection of:

- Safeguarding
- Mental health
- Addiction
- Tenancy enforcement
- Community safety
- Self-neglect

Each domain has its own thresholds, processes, and limitations. Without coordinated, flexible, trauma-informed approaches, individuals like David fall between service boundaries.

Housing teams focus on tenancy breaches and environmental risk. Mental health teams struggle to assess due to intoxication and inconsistent presentation. Addiction services cannot deliver structured interventions without stability. Social care cannot complete Care Act assessments without engagement. Community organisations face fluctuating willingness to interact.

This fragmentation reinforces the cycle of crisis.

6. Learning and Implications

David's situation highlights several systemic needs:

- **Assertive, persistent, trauma-informed outreach** that does not rely on scheduled appointments or stable engagement.
- **Mechanisms for progressing assessments even when engagement is inconsistent**, recognising that instability is the core presenting need.
- **Integrated multi-agency planning** that shares risk, responsibility, and information rather than waiting for one service to "unlock" the case.
- **Recognition of grief, trauma, and attachment** (e.g., his pets) as central to his emotional regulation and crisis patterns.
- **Housing-meal health-addiction coordination** to prevent eviction, deterioration, and escalating harm.

David's case is not a failure of professional effort. It is a predictable outcome of a system designed around structured engagement, applied to a person whose life circumstances make structured engagement almost impossible.

7. Conclusion

David remains at risk of harm, eviction, and further deterioration. His case demonstrates the urgent need for flexible statutory pathways that allow local authorities and partner agencies to identify and confirm care and support needs even when engagement is sporadic or crisis-driven. Instability is not a barrier to intervention—it is the primary need.