Case Study

A

My client A was referred to our Flintshire Outreach support service due to poor mental and physical health. My client, who is 50 years old, lives with her partner and her dog. Both my client and partner are on a substance misuse programme that they both attend regularly together.

My client unfortunately incurred drug debt and has in the past been a victim of drug related violence. Because of this the local authority agreed to relocate her to a different town where she is not known.

Since working with A I have successfully supported her through the process of moving, notifying the correct people that her tenancy has ended in her 2 bed council house, and notifying the utilities , benefits and the local authority that she had successfully started a new tenancy in a new purpose built one bedroom flat in a different location.

A has been supported to successfully applied for a Discretionary Assistance Fund for a new electric cooker as her old one was gas and there is no gas supply to the new flat.

A has also received £200 of food vouchers for 4 of the main supermarkets that can be used on separate occasions, this was a grant applied for from charity Family Action who are a partner organisation to Adferiad Recovery.

I have also supported her in filling out her PIP form and I consequently supported her in person at her telephone assessment.

She is now settled in her new home but has incurred large expenses in moving and therefore I have applied to The Biscuit Fund to see if they will grant her a one off payment.

Case Study

B

When B came onto the project, she was homeless and sofa surfing at her mother's house. Her relationship with her family was strained and she was still using heroin. All of B's previous tenancies had failed mainly due to her chaotic lifestyle and a lack of support.

Since B has been in the Doorstop property she has started making much better, more informed decisions and having her own tenancy has allowed her to stop using illicit substances which also means that she has stopped associating with other drug users. As B is no longer using drugs she is no longer getting in trouble with the police and all of the anti-social behaviour has also ceased. B has now made friends with her neighbours, settled into her local area and feels safe in her own home.

With support B has learnt to manage her accommodation and tenancy very well, her property is always kept clean and tidy, her bills are always paid in full and on time and she is always available for any health and safety checks.

When B began her support with Nacro her physical health was poor, she had just had a major heart operation but had continued using drugs during and after the procedure. Her legs were completely ulcerated which left her unable to walk for more than a few minutes at a time.

Over the last 2 years B has engaged well with her surgeon, GP, SMS key-worker and district nurse well and attended all of her appointments and her physical health has improved massively. B has reduced her methadone script from 90ml daily to 27 ml before swapping her medication over to Espirinol for the final stages of her reduction plan. B has stopped using her pregabalins and even given up smoking. After over a year of district nurse appointments her legs have healed up really well and she is now able to walk much further without any pain and states that her physical health is the best it has been for years.

Managing relationships and engagement has always been an issue for B in the past and she has a young son who lives with foster parents in England. With support, B has really worked hard on her relationships and she now gets on very well with her family. She is having her son for overnight stays while she is being assessed by social services with a view to having full custody again. Her relationships with her support services has also improved and she engages extremely well with her key-workers and social services.

Both before and during the lockdown B has made meaningful use of her time and has taken responsibility herself to enrol on and attend educational and recreational courses and groups in the community and online. She has completed a level 2 Health and Social Care college course.

B has been supported to receive the correct benefits. She is now currently in receipt of UC and PIP which she manages very well on her own. TW does have outstanding rent arrears which in the past she would have ignored but she has made a conscious effort to clear all of her debts and has set up repayment plans for any monies owed.

B reached the point where she wanted to start working again and successfully applied for a part time job which she really enjoys. She was quickly promoted to a senior member of her team in work which she is very proud of.

Having been through the move on panel, she has just been offered her own tenancy in a 2 bed property. B is now 10 months pregnant now and in a long term relationship with her partner who she would eventually like to live with as a family unit. B is very excited about this and the prospect of potentially getting her son back and she sees it as the next stage in her life.

Case Study

C

C arrived at the Glanrafon Homeless Hub in mid 2022, after spending a period of time sleeping on a workshop floor for a few months. He had found himself homeless after an assault by a family member he had previously been living with. C felt too unsafe to remain with his family member and they have subsequently been charged with assault.

C's health took a decline while he was living the workshop as he was unable to control his diabetes and became malnourished due to having no cooking facilities and was unable to maintain a balanced diet to control his diabetic ketone levels, which were dangerously high when he arrived and was on the verge of being admitted to hospital.

During his time at the Homeless Hub C has been supported to use the kitchen facilities and has been issued a slow cooker to be able to cook and maintain a balanced diet in line with his diabetes requirements. This along with his medication has resulted in his Ketone levels stabilizing and a 3kg gain in weight.

Now C is more stable and settled he has been attending all his medical appointments. C now has regular appointments with a diabetic nurse to monitor his levels and adjust his medication. He has also been encouraged to attend appointments with audiology and now has new hearing aids, which has alleviated his fear of attending appointments, which he did not like doing because he got frustrated not being able to hear what was being said.

As well as his physical health, his mental health has improved substantially. He has been attending counselling sessions which have helped him process the trauma he experienced when assaulted by his brother. He is also less stressed now the court case has been dealt with.

C has also been supported to manage his finances and apply for all the relevant benefits. This has all resulted in a positive outcome for him. He is now ready to live independently and has had an offer of a property which he has accepted and is waiting for a move in date.

Case Study

D

D was referred to the project due to losing his previous accommodation, in Denbigh. But was in temporary accommodation in Connahs Quay. He had rent arrears with previous private landlady; He was unsure of the amount owed; staff supported him to contact the landlady to set up a payment plan.

Although he left messages and phoned her, he didn't receive any communication for months. So, he put the money aside each month, for when he could pay the rent arrears that he owed. which he adhered to; He also was paying off HB arrears from his previous tenancy which he paid off while at GBV fulfilling his debt within his stay here.

He was put forward for move on which was declined in the interim, but then when explained to FCC the situation regarding the rent arrears and he was put forward again and accepted on to Band 1. He is now waiting to hear about a property. D has engaged excellently since the beginning and showed early on that he is capable of independent living.

D felt quite low about the situation he had found himself in. Being in supported living. This was originally due to a relationship breakdown. At the time Barry was in a bad place in his life But being at GBV and having the support from the staff he feels he is in a much better place in his life. D said that he didn't suffer with depression, that he just felt low now and again. He didn't have outside agency intervention for this as he doesn't feel he needs it.

D has a few medical issues. He has diabetes, which he found difficult to find the right diet for him, staff supported him by printing off healthy diets for people with diabetes, he used a few recipes that staff have provided and eats more healthily now.

He has a back injury for which he is on prescribed medication for. But at times he does find it difficult to walk distances and especially upstairs. Staff supported him to apply and receive a bus pass as he is registered disabled. D had been supported in registering with a local GP he collects his medication on a weekly basis. He is also registered with a dental surgery, in the area. D was an active person in the past, but due to his physical health this isn't possible. He has helped family members with less strenuous jobs in their property, he feels he likes to stay active. But knows if he over does something he will be in a lot of pain.

D no longer has issues with drugs and alcohol. As he said this led to offending behaviour in his youth. He does have the occasional social drink with his son now and then. But states this isn't a problem.

D has worked well with staff, attending support. He respected everyone in the project, as they did him. He also keeps in contact with his family who he visited regularly. He has a good family network around him. He hopes to move to a property near them, so they can continue to support him.

Case Study

E

E self-referred to the service when they visited a community hub based at Salvation Army in Connah's Quay. E explained that their neighbour was making excessive noise at inappropriate times and made them feel uncomfortable in their own home. E didn't feel safe or comfortable at home.

E explained that they were living in a HMO and they worked early shifts which meant they needed to ensure they had enough sleep. Due to the noise, they had not been able to sleep properly and had been missing shifts and falling behind on the rent, putting them at risk of losing their home.

E also explained that they are autistic. They had not tried approaching their neighbour as they did not have the confidence to do so.

Staff explained about the Conflict Resolution Service and mediation to E, and E asked to be referred to the service. Staff advised E to contact their landlord to inform them of their situation and that they have been referred to the service.

After some thought E contacted their landlord and the landlord consented for staff to contact them. The landlord was unaware of the noise being made by the neighbours having a negative effect on E and was keen to make things right. The landlord proceeded to work with the neighbour and E to come to a solution and things improved.

E is now comfortable again at home and submitted a compliment to the service for the support received.

Case Study

F

I have worked with this gentleman for the past 18 months, I started to visit him on a weekly basis as a welfare visit. I was made aware by neighbours that he was a vulnerable person, and they said he didn't appear to be himself.

After several months F had the confidence to approach me on one of my visits, he stated that his bank account was empty and that he had spoken to the bank to request a new card. After being shown his bank statements it was clearly apparent that he was victim of fraud. After several hours of speak to his bank, cancelling his card, going back over 12 months through his statements, and logging the fraud with the Police.

With support F managed to retrieve just over £4,000.00. We contacted Safeguarding and after 6 months of persistent emails and calls, I finally managed to secure specialist Social worker to look into F's long term Welfare.

I made a referral to Social Services to ask for assistance for F as he was asking me to assist him with reading his mail and making appointments for him. I had liaised with his GP surgery via calls and emails to get assistance as he was having issues with his balance. F has had several falls, one at a family wedding including numerous at home. It was clear that he hadn't had a review for his medication either for several years.

Since then I have assisted F with booking hospital appointments, Psychiatrist, mental health team to link back in, Chiropody, Community Nurse Assessment, and community transport. F has been having input from Occupational Therapy to ensure he has a ramp outside the front door to ensure he can access his community on his new scooter.

With support F has been liaising with the Housing Officer, Anti-Social Behaviour Officer and the Police due to issues with his new neighbour around anti-social behaviour and dog fouling outside his patio door.

He's now open to Social Services and I am now in contact with his support worker from Safeguarding again as he has been a victim of fraud for the second time and I have suggested again that he requires an appointee to manage his finances.

Over the last 3 months we have been running the Warm Hubs and as F resides in his community. Due to his current mobility issues I have ensured and delivered to F a ready meals and soup on a daily basis.