

**Pathways for
vulnerable
groups**

Annex B

Offenders (including Prison Discharge)

	Referral	Assessment	Possible Intervention	Outcomes
Activities	<p>A Level 2 or 3 offender who is threatened with homelessness after spending a period of time in stabilising approved premises will either self-refer, or be referred to the Welfare and Housing Services via the Langley Trust in cooperation with their Probation Officer.</p> <p>If the person is a level 1 offender, they can be referred directly via Integrated Offender Management to the Welfare and Housing Services using the agreed Housing referral form</p>	<ul style="list-style-type: none"> Offenders categorised as MAPPA Level 2 & 3 due to be discharged from custody who will be homeless will have an assessment carried out by the Probation Officer of the needs of the individual and carry out a risk assessment, taking in to consideration suitability of any property to be discharged to. The Probation Officer will be the lead agency in securing space for the individual who is Level 1 or 2 at Langley Trust for a period of 6 months and will hold the nomination rights in order to stabilise the individual. The trust will provide housing intensive support. 56 days prior to the end of the client's stay at the approved scheme, the Langley Trust will as the lead agency refer the client to the Welfare and Housing Team for move on options in partnership with the probation officer. The Welfare and Housing Officer will assess the client's eligibility and needs. Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) The move on option available for most clients in this category will be via the approved charity introduced. Welfare and Housing team will hold nomination rights. This charity will also implement floating support for those individuals who require it throughout their tenancy. The Langley Trust will provide risk assessments and a reference for the client to assist with move on into the private sector. MAPPA level 1 offenders can be referred by their Probation officers directly to the Welfare and Housing Team. 	<ul style="list-style-type: none"> If the client is categorised as Level 2 or 3 has med/high support need, upon release from custody they will be referred to the Langley Trust for 6 months After 6 months those Level 2 and 3 MAPPA offenders who are ready for move on will be referred to the Welfare and Housing Team If the client is Level 1 has no/low support need, they will be referred directly to the Welfare and Housing Team 56 days prior to release from Prison Clients will also be referred to other support agencies to meet other needs identified that are non-housing related. It is expected that the Probation Officer will recognise these needs and make appropriate referrals. 	<p>Clients with med/high support needs have the following options: usually MAPPA Levels 2 & 3.</p> <p>Approved premises- Langley Trust</p> <p>Supported Accommodation</p> <p>Return home</p> <p>Clients with no/low support needs have the following options e.g. Level 1 MAPPA category :</p> <p>Independent accommodation</p> <p>Rent deposit & Rent In Advance loan</p> <p>Return home</p>
Who is involved	<p>Probation officer</p> <p>Prison</p> <p>IOM</p> <p>Langley Trust</p>	<p>Probation Officer</p> <p>Langley Trust</p> <p>Welfare and Housing Officer</p> <p>Supported Accommodation Provider</p> <p>IOM</p>	<p>Langley Trust</p> <p>Social care</p> <p>MAPPA</p> <p>Langley Trust</p> <p>Community Mental Health Team</p> <p>Various community Charities</p> <p>Drug and Alcohol support</p>	



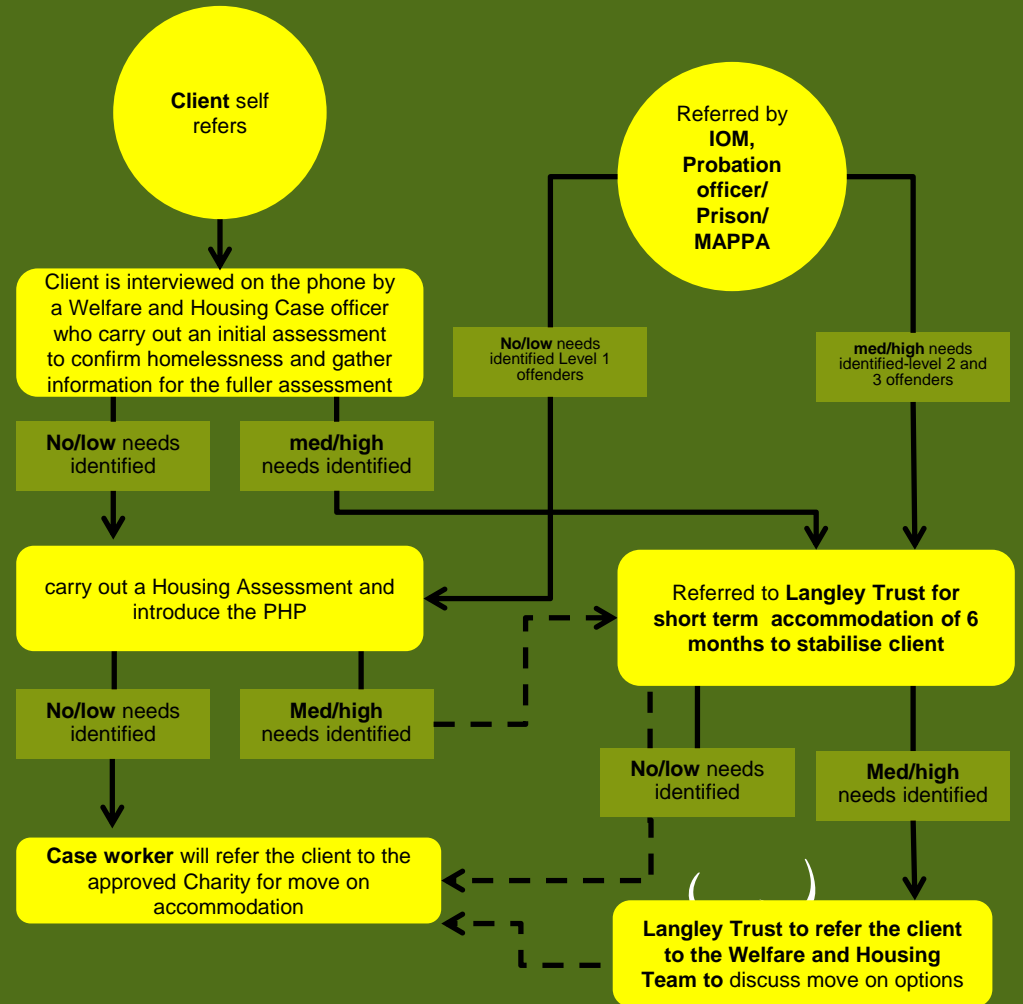
Getting ex-prisoners and offenders into stable housing can act as a gateway to effective resettlement including engaging with education or training, gaining employment and engaging with services where any other support needs may need to be addressed e.g. mental health, drugs/alcohol etc.

Offenders who are homeless or threatened with homelessness can approach Bracknell-Forest Council for advice and assistance to either prevent or relieve homelessness.

The Welfare and Housing Services have referral pathways protocols with some specific agencies that work with offenders who are homeless or at risk of homelessness. These agencies include the Integrated Offender Management team (IOM) and the Probation Service for clients who are on Probation that are high risk or monitored under the Multi Agency Public protection Arrangements (MAPPA).

Welfare and Housing Officers will undertake a detailed housing needs assessment of all customers who present for assistance or referred in by other agencies. For those customers who may have additional support needs a full needs and risk assessment is also completed to ensure that the most appropriate housing option is advised. A personalized housing plan will be drawn up confirming any advice given, how the Council will assist the customer and what the customer needs to do to help themselves.

The Welfare and Housing Team work collaboratively with internal and external partners to secure affordable permanent housing for their customers i.e. mediation to return home, advice on Social Housing, Private rented accommodation or supported accommodation. The team also refer customers to agencies where any unmet needs have been identified following an assessment i.e. New Hope drug and alcohol services.



Care Leavers

	Referral	Assessment	Possible Intervention	Outcomes
Activities	<p>A care leaver who is threatened with homelessness either self-refers to Welfare and Housing Team or is referred through Children Social Care</p>	<ul style="list-style-type: none"> Where possible- The Allocated Social Worker/ PA will make a referral to Lookahead supported accommodation via the Young People Resourcing Panel to prevent the client's homelessness If the referral is unsuccessful, the client will self refer or be referred by Social Services to Housing. An assessment is carried out by the Housing and Welfare Officer based on the information provided from the referral- this includes a needs and risk assessment if support needs have been identified Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) If the client has medium/ high support needs, they will be referred to the approved charity who will procure private rented accommodation and also provide floating support in partnership with the YP's PA/ Social Worker. If the client has low/no support needs a referral will be made to the housing charity to procure accommodation in the private sector and Social Services will lead on the support element to help client sustain their tenancy. 	<ul style="list-style-type: none"> If the client has med support need, The client will be referred to Lookahead. If the referral to Lookahead is rejected they will be referred to the Welfare and Housing Officer If the client has no/low support need, they will be referred to Lookahead or housing charity. Clients will also be referred to other support agencies to meet other needs identified that are non-housing related 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Supported accommodation Social housing nomination* Return home Private rented with floating support <p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Private rented- with floating support Social housing nomination* Supported accommodation Return home <p>Care leavers may receive priority banding under the allocations policy</p>
Who is involved	<p>Children Social Care</p>	<p>Welfare and Housing Officer</p> <p>Social Worker/ PA</p> <p>Lookahead Supported Accommodation Provider</p> <p>Housing Charity</p>	<p>If the client has med/high support needs:</p> <p>Social care</p> <p>Welfare and Housing floating support partners</p> <p>Young People's Resourcing Panel/ VCLS meeting</p> <p>Housing accommodation partners</p>	

Hospital discharges

	Referral	Assessment	Possible Intervention	Outcomes
Activities	<p>An individual who is identified by the hospital as homeless or threatened with homelessness is referred to Welfare and Housing Team</p>	<ul style="list-style-type: none"> An assessment is carried out by the Welfare and Housing Case worker based on the information provided from the referral- this includes a needs and risk assessment if support needs have been identified If the client's accommodation is no longer suitable to return to by virtue of the medical condition, the Hospital Discharge Team will ensure that a Occupational Therapist has assessed and provided an assessment. Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) If The client is already Homeless, a referral should be made to Adult Social Care and CMHT (in cases if the client presents with MH issues.) 	<ul style="list-style-type: none"> In circumstances where the property the client is being discharged into is no longer suitable: the Welfare and Housing Officer will Contact Forest Care by calling 01344 786599 for an initial discussion In all cases of Hospital Discharges there will be an OT report with an assessment done in the home. The Welfare and Housing Officer will use this information and make a referral for the Disabled Facilities Grant where relevant. The welfare and Housing Officer to consider if the client may have a severe or life threatening medical condition which warrants a Band A award under the register The request will be emailed to the Housing Technical Officer. If the client is homeless, the Welfare and Housing Officer can refer the case to the Approved Housing Charity for rehousing 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Supported accommodation Private rented sector with floating support Return home Management transfer
Who is involved	<p>Hospital</p>	<ul style="list-style-type: none"> Hospital Discharge Team OT Housing and Welfare Officer Adult Social Care CMHT 	<p>If the client has med/high support needs:</p> <ul style="list-style-type: none"> Social care Housing floating support partners Homeless forum Housing Charity and floating support 	<p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Independent accommodation Return home

Housing services have an important role to play in supporting the health and wellbeing of the population and offers a valuable solution in both discharges from hospitals and the prevention of new admissions.

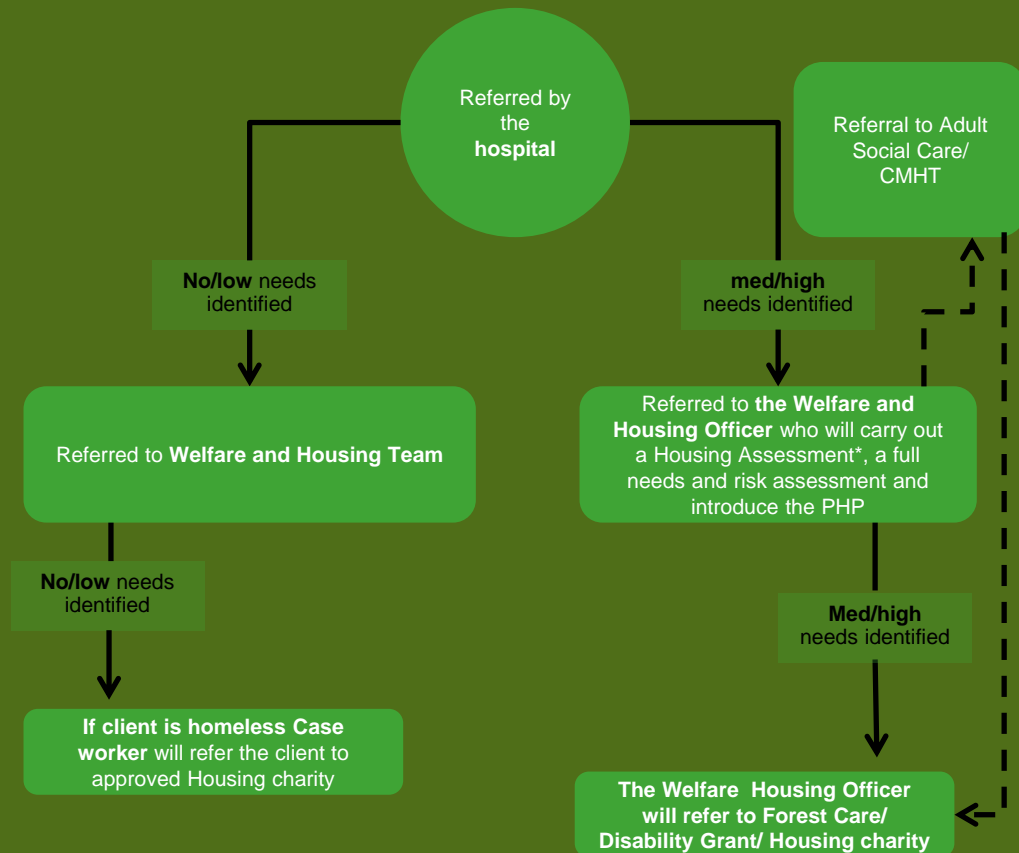
In partnership with social care and health services Housing have a working protocol with hospitals and other health agencies for customers who are homeless, threatened with homelessness or have a housing need.

It aims to help people with a range of circumstances e.g. fleeing domestic abuse, young single homeless households, homeless families, people with complex multiple needs, alcohol and or drug addiction, a history of offending, learning difficulties, physical disabilities and mental health needs.

Patients are usually asked for their address on admission to a ward in hospital so it is therefore requested that, all hospital discharge referrals are made at this point if a person has no fixed abode. For those who have an address, the admission form should include details about their accommodation, and the medical professional can assess the likelihood of discharge back to the same property in light of the procedure, if it appears at face value, this will be an issue, again a referral should be made at this stage and not at the discharge stage. Often potential homelessness can be prevented, but even where this is not possible it is much easier for the patient and the Local Authority to find the accommodation and support the customer if a referral is made at the earliest point possible.

The Housing Team will undertake a detailed housing needs of all customers who present for assistance or referred in by hospitals and health agencies. A personalized housing plan will be drawn up confirming any advice given, how the Council will assist the customer and what the customer needs to do to help themselves.

The Housing Team work collaboratively with internal and external partners to secure affordable permanent housing for their customers i.e. mediation to return home, advice on Social Housing (including transfers), adaptations, private rented accommodation or supported accommodation.



Leaving Armed Forces

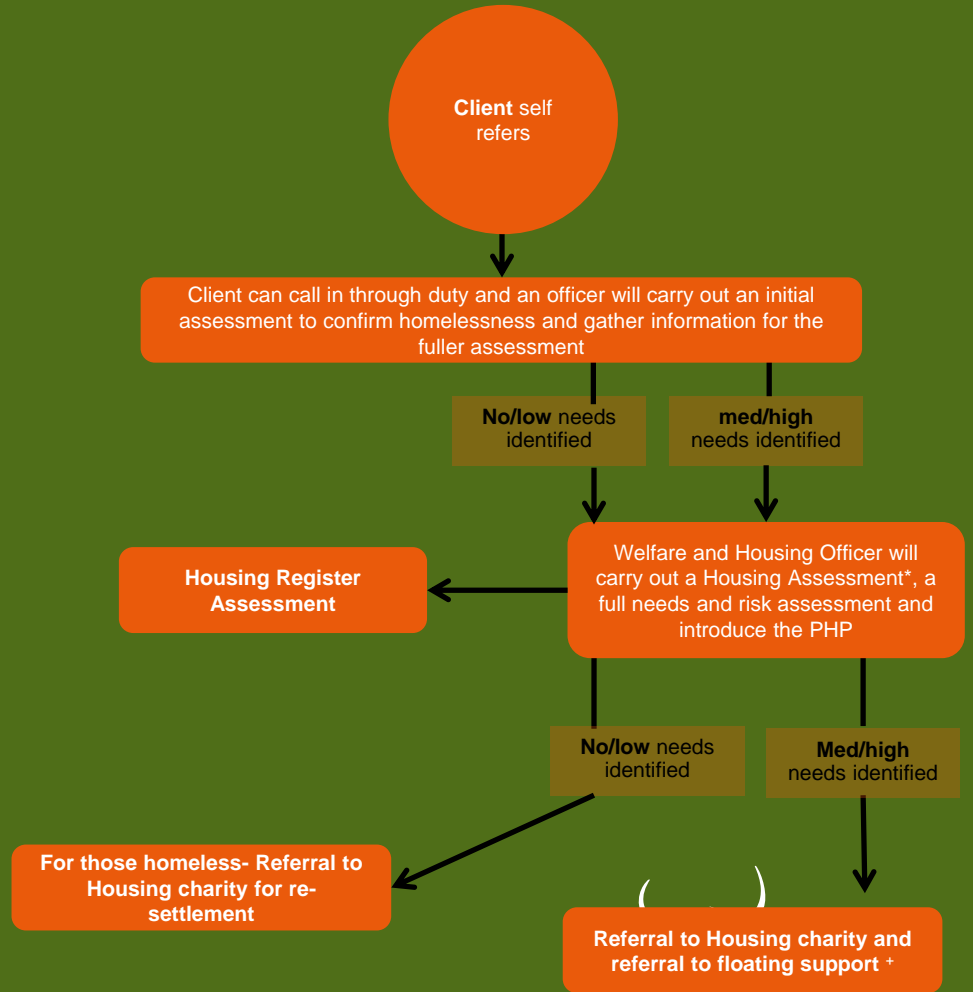
	Referral	Assessment	Possible Intervention	Outcomes
Activities	An individual leaving the armed forces who is homeless or threatened with homelessness will self-refer to the welfare and Housing Team	<ul style="list-style-type: none"> An assessment is carried out by the Welfare and Housing Officer Support based on the information provided from the referral- this includes a needs and risk assessment if support needs have been identified Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) 	<ul style="list-style-type: none"> If the client has med/high support need, they will be referred to the Approved Housing Charity and a referral will be made for floating support.. If the client has no/low support need, they will be referred to the Approved Housing charity for rehousing Clients will also be referred to other support agencies to meet other needs identified that are non-housing related 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Floating support Resettlement via the private rented sector Return home Social housing accommodation *
Who is involved		Welfare and Housing Officer	<p>If the client has med/high support needs:</p> <ul style="list-style-type: none"> Social care floating support partners Homeless case conference Housing charity 	<p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Independent accommodation Return home Social housing accommodation *

* Armed forces may receive priority banding under the allocations policy

Customers who are being discharged from the Armed Forces who have sustained serious injury, illness, medical condition, or disability during service which is attributable (wholly or partly) to the person's service, would be deemed as vulnerable if they approach the council as homeless or threatened with homelessness.

The Welfare and Housing Team would carry out a detailed housing needs assessment of all customers who present for assistance or have been referred by a partner agency. A personalized housing plan will then be drawn up confirming any advice given, how the Council will assist and what the customer may need to do to help themselves.

There is an additional discretionary housing option available to customers who have been discharged from the armed forces or serving former members of the Reserve Forces who need to move because of a serious injury, medical condition or disability sustained as a result of their service. They can be awarded priority banding under the Council's current allocation scheme for Social Housing.



Domestic Abuse

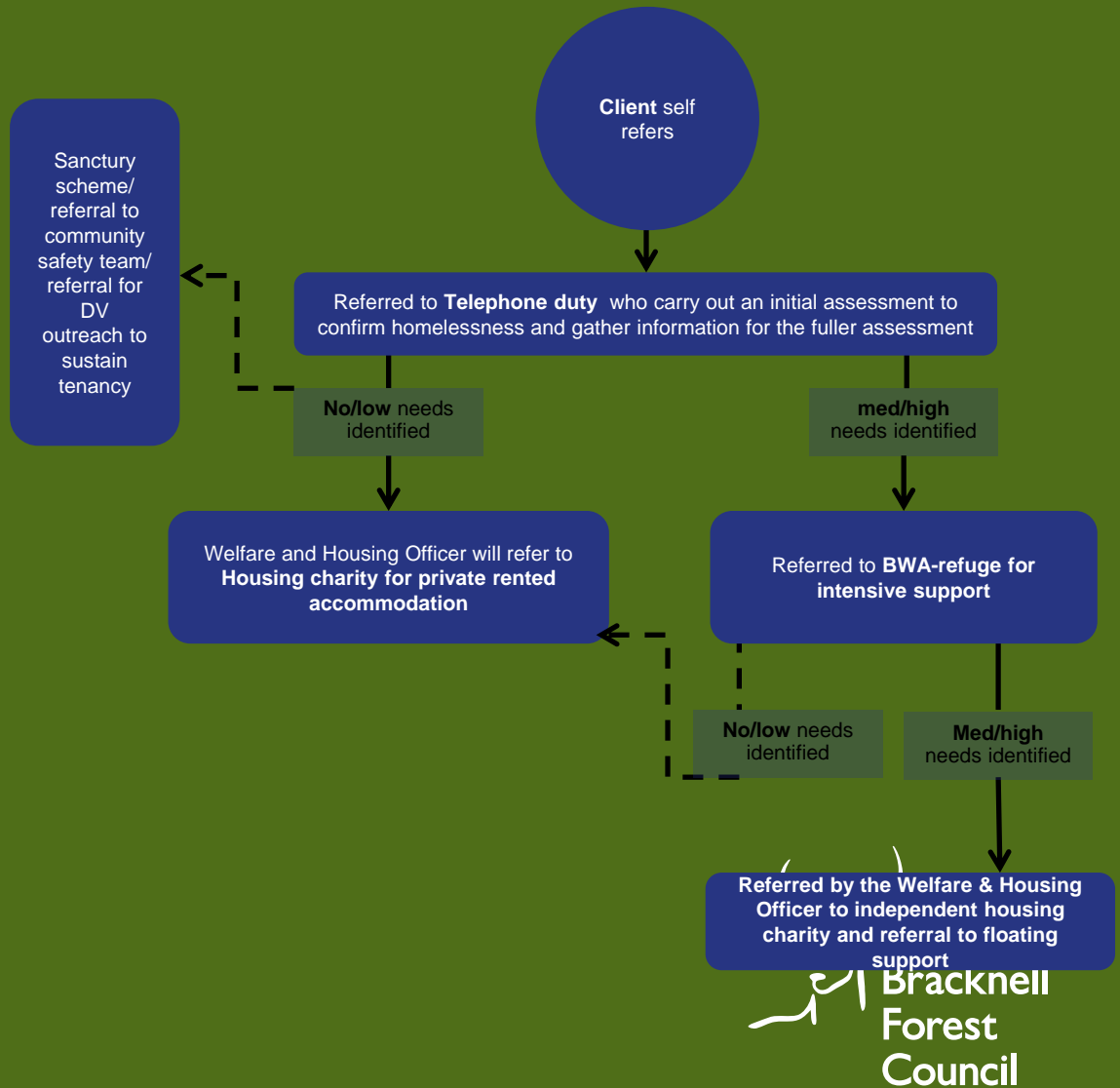
	Referral	Assessment	Possible Intervention	Outcomes
Activities	<p>An individual experiencing domestic violence and as a result is homeless or threatened with homelessness will self refer or be referred through a partner agency to the Welfare and Housing Team</p>	<ul style="list-style-type: none"> An assessment is carried out by the Housing and Welfare Officer based on the information provided from the referral- this includes a needs and risk assessment if support needs have been identified Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) 	<ul style="list-style-type: none"> If the client has med/high support need and has self referred consider placement at refuge If referred by the refuge consider private rented accommodation through approved housing charity with floating support If the client has no/low support need, they will be referred to housing charity for re-settlement in to the private sector. Clients will also be referred to other support agencies to meet other needs identified that are non-housing related 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Refuge Resettlement in another borough Independent accommodation Sanctuary Scheme Referral to the community safety team Referral to the Domestic Violence outreach team
Who is involved	<p>Partner agency Berkshire Women's Aid/ CAB</p>	<p>Welfare and Housing Officer</p>	<p>If the client has med/high support needs:</p> <ul style="list-style-type: none"> Social care floating support partners Homeless Case conference Private rented accommodation via housing Accommodation Officer- for those with family 	<p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Independent accommodation Resettlement in another borough

Domestic abuse includes any incident of threatening behaviour, violence or abuse. The abuse can be psychological, physical, social, financial, or emotional. Domestic abuse can happen between two people who are or were intimate partners or family members, regardless of their gender or sexuality.

Anyone experiencing domestic violence can approach The Welfare and Housing Team for assistance and information disclosed by a customer should remain confidential.

A full assessment would be completed and a personal housing plan created giving the customer advice on finding alternative accommodation and signposting and referrals to any relevant support agencies.

Welfare and Housing Team work in partnership with Berkshire Women's Aid which is an independent charity working across Bracknell, providing life-saving support to women and children survivors of domestic or sexual violence.



Mental Health

	Referral	Assessment	Possible Intervention	Outcomes
Activities	<p>A person with mental health needs either self-refers to Welfare and Housing Team or is referred by a agency working with clients who have mental health conditions</p>	<ul style="list-style-type: none"> An assessment is carried out by the Housing and Welfare Officer based on the information provided from the referral- this includes a needs and risk assessment if support needs have been identified This will be informed by the RAS assessment completed by the CMHT Team including a decision as to why CMHT Supported accommodation is unsuitable. Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) 	<ul style="list-style-type: none"> If the client has med/high support need, they will be referred to the housing charity and a referral will be made for floating support If the client has no/low support need, they will be referred to the housing charity for resettlement only. Clients will also be referred to other support agencies to meet other needs identified that are non-housing related 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Supported accommodation-CMHT Private rented with floating support Return home
Who is involved	<p>Partner agency (e.g. CMHT)</p>	<p>Housing and Welfare Officer</p> <p>CMHT</p>	<p>If the client has med/high support needs:</p> <ul style="list-style-type: none"> Social care Housing floating support partners Complex Needs Advisory Panel Housing support accommodation partners 	<p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Independent accommodation Return home

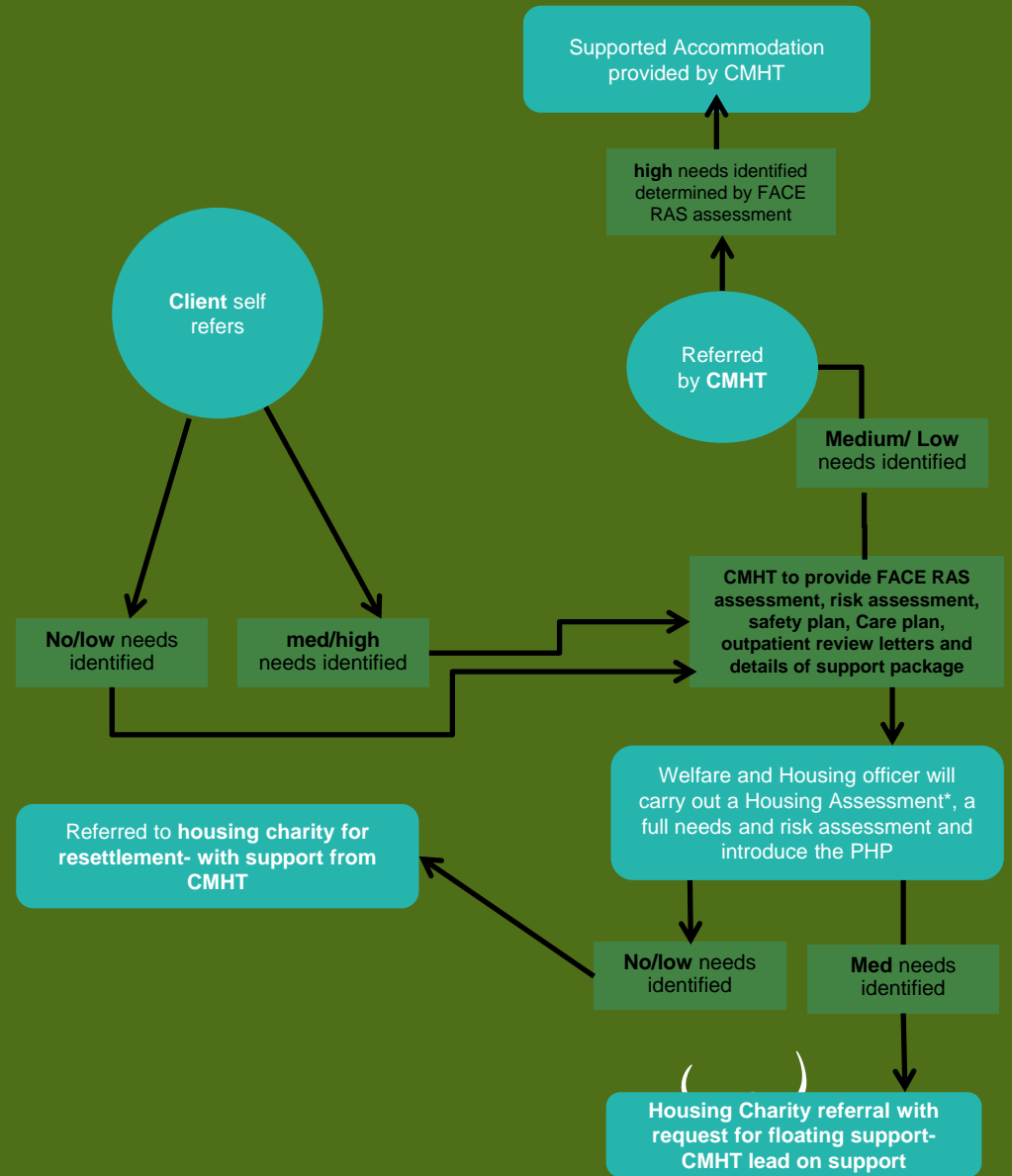
Having a home which is both safe and affordable is extremely important for general health. Living in poor housing being homeless or threatened with homelessness could increase chances of developing a mental health problem, or could make an existing one harder to manage.

The Welfare and Housing Team work in partnership with a range of agencies to ensure that we meet the housing and support needs of those customers who suffer from mental health issues.

The Welfare and Housing Team would carry out a detailed housing needs and risk assessment of all customers who present for assistance or have been referred by a partner agency. A personalized housing plan will then be drawn up confirming any advice given, how the Council will assist and what the customer may need to do to help themselves.

There is a separate Mental health housing pathway for those customers where Welfare and Housing team's options may not meet their specific needs. This will be informed by the FACE RAS assessment.

Bracknell-Forest Council continuously review the advice support and advocacy services available to customers with mental health issues across the borough. Where a client may be eligible for a personal budget an outreach support package of care is co-ordinated via Social Care.



Rough Sleepers

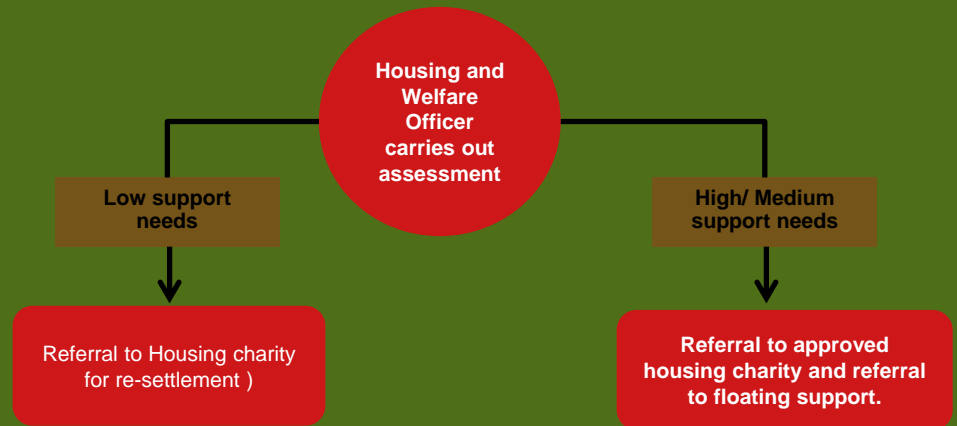
Referral	Assessment	Possible intervention	Outcomes
<ul style="list-style-type: none"> An individual who has been identified as a rough sleeper by the Community Safety Team, Pilgrim Hearts, Kerith Centre, street link or All night Café in Camberley will be referred to the Welfare and Housing Team. Various floating support agencies will alert the Welfare and Housing Team if they see that a person is at risk of becoming a rough sleeper 	<ul style="list-style-type: none"> New to system: the Welfare and Housing Officer carry out an initial assessment with the community safety team and the night shelter providers in the area- includes a needs and risk assessment if support needs have been identified Following this assessment, the client will be introduced to the Personal Housing Plan (PHP) Known to system: the most complex cases can be referred to the Homeless case conference If the Welfare and Housing Officer has no reason to believe the client is in Priority Need- Case worker to liaise with night shelters to continue to accommodate client for 56 day relief period whilst the case worker works with individual. 	<p>Following the Housing assessment:</p> <ul style="list-style-type: none"> If the client has med/high support needs, they will be referred to the approved Housing Charity and for floating support provisions at the same time. If the client has no/low support needs, they will be referred to the approved Housing Charity for resettlement. Clients will also be referred to other support agencies to meet other needs identified that are non-housing related 	<p>Clients with med/high support needs have the following options:</p> <ul style="list-style-type: none"> Supported accommodation for young people Resettlement in to the private rented sector Return home <p>Clients with no/low support needs have the following options:</p> <ul style="list-style-type: none"> Independent accommodation Return home
<ul style="list-style-type: none"> Community Safety Team Pilgrim Hearts Floating support provider Housing and Welfare Officer 	<ul style="list-style-type: none"> Housing and Welfare Team 	<p>If the client has med/high support needs:</p> <ul style="list-style-type: none"> Social care Housing floating support partners Homeless case conference 	

Rough sleeping is defined by the Government as 'people sleeping, or bedded down, in the open air (such as on the streets, or in doorways, parks or bus shelters); people in buildings or other places not designed for habitation (such as barns, sheds, car parks, cars, derelict boats, stations, or 'bashes').

Bracknell Forest is committed to ending rough sleeping and will introduce a Housing Charity to secure affordable private rented accommodation.

The Housing team look at options to reconnect people to their own area or to support them to find accommodation to meet their specific needs. The council has working protocols with these agencies to access Housing Services for those customers who have a local connection to Bracknell-Forest. Our models with the aim to eliminate rough sleeping in the borough by 2020 in collaboration with partner agencies.

There are some categories of rough sleepers we cannot assist due to immigration restrictions. In these cases, the person should be signposted to the CAB to assist them by reconnecting with their country of origin.



Learning Disabilities/ASD/ Autism

	Referral	Assessment	Outcomes
Activities	<p>A person who has learning disabilities and is homeless or threatened with homelessness will be referred to Community Team for People with Learning Disabilities.</p>	<ul style="list-style-type: none"> CTPLD/ CTPASD team will assist with support with housing in the first instance and secure supported residential living where appropriate for those who are eligible under the Care Act 2014 based on assessment and if unsuccessful will refer to the Welfare and Housing Team. Referrals to the Welfare and Housing team can be made using the duty line 01344352010 between 10-2pm/. If the client's home could be adapted to make it suitable in light of the disabilities, housing and CTPLD will explore these options. In most cases CTPLD/ CTPASD team will lead on this unless the client does not meet the eligibility criteria for their assistance. Otherwise, if client is homeless, referral will be made to the Welfare and Housing Team. The team will assess the housing need and refer to housing charity and CTPLD will lead on the support package. CTPLD will always provide the referral form and any requested additional documents to the housing team. 	<p>If there are suitable voids identified by CTPLD or they are successful in sourcing appropriate provision outside of voids, they have the following option:</p> <p>Supported living scheme led by CTPLD/ CTPASD</p> <p>If client has no/low support needs a referral will be made to the Welfare and Housing Team</p> <p>Private rented accommodation with funded outreach support by CTPLD/ CTPASD</p>
Who is involved	<p>Social Services</p> <p>CTPLD</p> <p>CTPASD</p>	<p>CTPLD/ CTPASD</p> <p>Welfare and Housing Team</p>	

