Adult Placement or Shared Lives

Margaret Dorney has trained for Norman Mark since 2006. Her specialties include Learning Disabilities and Mental Health training. Margaret also provides supportive lodgings for people in her own home via the Adult Placement Scheme which is managed by the local authority.

I currently offer supportive lodgings to three women, all have a variety of mental health needs, two have mild learning disabilities, and one woman also has a physical disability.

I began doing this work in 1998. I had a spare room and thought about renting it out however since buying my flat I have always been keen to use my home to serve people, so rather than simply rent out to a lodger I chose to pursue offering supportive lodgings.

Having worked for Social Services for over a decade I was aware of the scheme and knew quite a few service users who seemed really happy in their placements. I called my local scheme and they send me some information to read.

This was followed by an initial visit from two workers where they explained about the application process and we discussed my motivation for wanting to be a carer. They knew I had worked in the social care field for a long time and told me my experience would be invaluable to a carer role as many AP carers have not had such extensive experience or worked in social service settings.

They said the flat was fine but I would need to comply with health and safety by installing fire detectors on each landing and a fire blanket & extinguisher in the kitchen. This was followed up by a visit by a health and safety officer –the scheme tap into other agencies such as this one housed in the local social services building. Following this visit I completed the relevant application form plus CRB and sent it in.

All prospective carer's are taken to a panel for approval. This is done by a support worker, carers are not present in person, the approval process happens annually once approved. Once a year I am asked to evidence in writing how I meet the Care Standards within my home. I am given a few of the standards each time to respond to. I can also add any comments. For example, I remember saying last time that I could not do this work with the women that are currently in placement without the support of a multi-disciplinary team, in particular mental health workers such as CPN and SLAM; all three have very complex MH needs. The women are also sent forms asking them questions about living here; what they like, don't like, who they can talk to if they are not happy etc . Other

professionals and their families are also sent these forms to comment on me and the care I offer; to date this has been a very affirming process for me.

Historically AP carers have been visited by inspectors but now the Scheme is inspected and they have to evidence how the scheme is meeting the standards etc. Funding comes via Supporting People and they do like to visit a few placements each year and this year it was our turn!

Two inspectors came; they spoke to the women privately first and then me. I was told that the women all said they were very happy living with me and asked for my comments on the scheme and care management input etc. One of my comments was that I believe all clients with duel diagnosis should have an allocated care manager.

That in the last year one of the women had been sectioned again, she did not have a named SW and had to spent 2 months in an acute unit where her learning disability needs were not fully understood or supported. Due to shortage of beds in mental health services she (and others under section) was constantly moved at night to various hospitals around London and brought back the next morning to spend her day on the ward. I was constantly advocating for her and also wrote about my concerns to the NHS about this afterwards.

She was then discharged without letting her CPN know and despite my saying she was not well enough to come home, no care plan was in place; it was a long night as she was very unwell. I was up all night with her (and yes I had been training that day!) called the ward, local emergency MH services and everybody said to call the police. I now understand that the fastest route in the middle of the night for someone in MH crisis is to call the police who then take them to the local hospital where they will be seen.

Then as usual it was me that did all the ringing around the next day in order to get her help e.g. Setting up the meeting with her physiatrist and CPN, she was sectioned again the very next morning and we were given a verbal apology as she should not have been discharged in the first place. This is the 2nd time this has happened so I have now insisted that more a detailed care plan and risk assessment be written up which includes signs she is unwell, some of them very subtle so that hospital staff are aware and the plan also clearly everybody's role when she is in crisis. I can access the out of duty services and I have found advice from Mental Health emergency services useful, however the out of duty care management team don't know the women, their background etc and it can be exhausting going through all the details needed whilst at the same time trying to support the person.

I have often been told that I do go beyond the call of duty in my role and in one way that is simply part of how I am. I am passionate about ensuring that the women's rights are upheld and they get the support they need etc however;

another side of this coin is I often don't have any choice; it is me that is woken in the middle of the night when there is a crisis – oh the joys of lone working!

Despite having care plans/risk assessments in place things often don't get included until there has been a situation. So for example, I have now ensured that if and when this client needs to be in hospital again that she is put in a ward where staff are trained to work with LD too. That she is not discharged without a multi-disciplinary meeting taking place before hand and that the care manager does the liaising with professionals so that I can get on and support.

I told the inspectors that due to my long experience and knowledge I am aware of resources and often know what to do which helps, the inspectors agreed but also said what about the carer's that don't have my experience/knowledge, how do they cope. A good question, I would imagine it must be very difficult. – Which is why training is ESSENTIAL!!

The four storey house consists of two flats.
I brought Flat 2 a two bed roomed property in 1992. The first lodger and I shared this two bed roomed flat for eight years. During the 8 years of sharing with lodger 1 I felt like a lived in a goldfish bowl as professionals would often come to our home for meetings and reviews and I often missed my privacy. I would be on the phone in the sitting room with door closed and open it to find lodger outside door listening to my conversation.

Our elderly neighbor sadly passed away in 2005 and I was able to buy Flat 1.
I totally renovated, including building an extension so it is now a 3 bed roomed flat. I then moved down to the basement of the house which has bedroom, bathroom, kitchen and front room and is totally separated off from the rest of the house by a locked door at the top of the stairs. If they need me they knock or when feeling lazy to come down stairs they call my mobile. I go up each day to ensure all is well. So in reality I now live totally separately from the women-it's more a case of semi-supported accoadation. Due to my training role and personal life this arrangement now suits me far better. I am able to have 'time off' and separation from work.
When I am away I have two 2nd carer's approved by the scheme who stay over in the spare room. Although I can come and go as much as I like in the day I have to have someone stay overnight as the women cannot be left alone overnight.

My responsibilities include supporting the women to live as independently as possible. All three have different needs. One can manage most aspects of her life but needs vast amounts of time in terms of emotional and support due to her MH needs.

Practical support –include supporting with housework, cooking, shopping, budgeting, making appointments and going with when required, recording and liaising with other professionals and families.

Advocacy, emotional support and monitoring their mental health which during times of crisis includes ensuring medication are complied with.

The key I have found is knowing when to step in and when to stand back.

A matching process takes place, I am sent details of referrals to the scheme of women they feel would benefit from living here. They would come around for a cup of coffee, look around the home and chat with me. If this goes well they come again for dinner. Then an overnight visit, then a weekend visit and then move in.

This is a big difference to usual social care work where we cannot chose clients we want to work with-in this setting we both have a clear choice. A month either way is needed to end a placement.

They can self refer or be referred to the scheme by professionals or families.
Care plans and Risk assessments are completed before a person moves in and updated each year at their review which is held at home and attended by whoever they want them. Care management hosts these meetings. Once in placement the women all have care managers who work alongside the scheme they can talk to for support along with their other supports and I have support via a supervisor.

I am considered self employed but work as an approved carer for the scheme.

The scheme taps into local authority training courses and also offer courses specifically designed for carers such as Medication in Adult Placement settings.

I am self employed and use an accountant. Carers do not pay tax on their earnings from caring much like foster carers. There are base rate fees which are topped up via an assessment of need.

This arrangement benefits the clients in a variety of ways that they would not have should they be in a more 'controlled environment because I think that AP is about as close as you can get to the principles of 'normalisation' and community inclusion. This is home to the women who live here and due to the set up they have lots of autonomy and more privacy than residential care.

The relationship is challenging because of the obvious tensions in the boundaries. The relationship I have built up with the women is different to other roles I have held. For example, they know my friends and family and enjoy social activities together-eating out, theater etc I often take them to visit my sister who lives at the coast- the boundaries are different and vary between carers. I am more 'friendly' but would not consider the women to be my friends as it is not an equal relationship; I am paid to care for them. I do not share much personal info

with them although they know about me naturally as we do live in the same house. I have gone out to dinner with members of their families to build relationships, something I would never condone in usual social care work.
I have learnt to take time off for myself more and the women know not to disturb me on Sundays unless there is an emergency.

On balance, however I fund this role very rewarding because I have seen the women develop in so many ways, their skills, their self esteem and confidence.

One of the best moments – when the 1st lodger moved in she had come from a much more supported setting. I remember telling her that we would get on each other's nerves from time to time and if I did or said anything she didn't like she should tell me. This process took a few years –for her to trust me- one day we were home together and I was chatting to her and she basically told me to shut up as she wasn't interested. This was such a significant shift- because I am a professional paid to support but we also share a home!

Worst moment. Visiting a lodger's mum in hospital after she had undergone an operation. She unexpectedly deteriorated and was rushed to Intensive Care where we were told she would not make the evening. For the next 5 hours I sat with her and her family and watched her mum die. I had sat with my own mother in the same hospital the previous year where she also died.

The women see me at my best but also my worst-such is life within Adult Placement- It isn't always easy and can be very demanding especially with their varying complex mental health support needs but I very much enjoy this work. Supporting the women has enriched my life as much as I try to enrich theirs.

For more information of Adult Placement or Shared Lives go to
Naaps website - National Association of Adult Placement