**Rethink Mental Illness**

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**What is the service?**

The Floating Support Service is a goal-orientated support service aiming to support individuals with aspects of independent living and community-based engagement. Our regular office hours are: 9am to 5pm.

**Please note due to COVID19 the service will not be visiting people in their homes or have an office base to meet clients until the Covid-19 restrictions change so support will mainly be offered over the phone and online. Depending on current Government guidelines, this support may be able to move back to some face to face provision as restrictions lift.**

**Who is the service for?**

The service is for adult residents of Harrow who have mental illness as a primary diagnosis and is aimed at those with low to medium mental health support needs who need support to enable them to maintain their home and access appropriate activities and services in the community. The service is also available for EMI (elderly mentally impaired) with support offered to build structure, signpost to appropriate services and engage with the community.

**Service aims:**

The service aims to support service users with the following:

* Support with the processes for Identifying and accessing suitable housing
* Setting up and maintaining a home
* Exploring suitability of living accommodation
* Managing finances including budgeting and claiming benefits
* Maximizing income
* Attending meetings and appointments including planning and scheduling
* Form filling and writing letters
* Developing independent living skills
* Improving and maintaining emotional wellbeing through social engagement and personal relationships
* Co-ordinating your support with other agencies
* Accessing and engaging with appropriate services including leisure, training, volunteering and employment

**Referrals**

New clients can be referred into our service where they will be assessed according to their needs. Our staff will carry out both a risk assessment and a needs assessment and then agree a support plan with the client.

We will need a risk assessment to be provided for every referral where possible, GP referrals excepted.

**Parameters of the service**

* The service will not provide housing management, personal care or health care functions. We will also not handle service users’ money.
* In order for this service to be effective, committed engagement is needed- this means attendance at regular scheduled meetings- weekly or fortnightly. If you miss more than two appointments, we will have a discussion with you about your ability to commit at this time. Missing a further appointment (3) could then (at the discretion of your support worker) lead to ceasing of the service until there is a better time for you to engage with your goals.
* We need commitment to the goal and actions agreed. We will help plan, encourage and motivate towards you reaching your goal and support you with information and tasks that are beyond your ability at this time but the majority of the actions towards the goals need to be coming from you.
* We can help you with processes and support towards gaining appropriate housing for you but are unable to guarantee an outcome as this is beyond our control
* Your goal must fit within the remit of the service- if we assess your needs are beyond the scope of the service, we will signpost you to a more appropriate provider.
* After discharge, you will not be able to access our service again for a period of one year, after which you can be referred back into the service if you have a new need for support.

**Moving on**

Our service is designed specifically to help enable clients to become more independent and able to manage their housing and related needs. As such the support our service offers will be goal-orientated and the support will finish once the goal has been achieved, with a focus on empowerment, promoting independence and encouraging move on. Our staff will create a plan together with the client which include both the support we agree to offer and also a moving on strategy to help enable the client to better manage their affairs. As part of the moving on plan, we will provide clients with an appropriate list of signpost services and agencies.

In addition, we will give you a call after 6 weeks to see how you are doing with your independent living and offer any further signposting that may be needed.