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## **Foreword**

At Aberdeen Cyrenians, we believe no one should be left to face crisis alone. Yet we know that too many people in our city still experience homelessness, poor health, and social isolation – often at the same time. These challenges are not simply the result of individual circumstances; they are shaped by the wider social determinants of health - housing, income, education, work, and access to care.

This Strategic Plan sets out how Aberdeen Cyrenians will respond to that reality over the next five years, with compassion, determination, and a focus on prevention.

Our ambition is clear: to prevent homelessness and unnecessary hospital admissions by taking a community based, public health approach. This means shifting the emphasis from reacting when people are in crisis to addressing the causes before they take hold. By working earlier, more holistically, and in closer partnership with our stakeholders, we can reduce pressure on emergency services, strengthen communities, and improve people's

This plan has been shaped together – with the voices of the people we support, our staff and volunteers, and our partners across Aberdeen. People with lived experience of homelessness, trauma, or exclusion have told us what works and what must change. Health and housing professionals, community groups, and local authorities have shared their expertise and insight. The result is a plan that reflects the reality on the ground, the national evidence, and the hopes we share for the future.

#### **OVER THE NEXT FIVE YEARS, WE WILL:**

- Focus on prevention and early intervention to stop problems escalating.
- Openiver integrated support that brings together housing, health, social care, and employability.
- Empower and include people so they can take control of their lives and contribute fully to our community.
- Orive collaboration and system change, using data and lived experience to influence policy and practice.
- Build the foundations for sustainable social change, ensuring our organisation is resilient, adaptable, and ready for the future.

We know we cannot achieve this alone. Real and lasting change will only happen when we stand shoulder-to-shoulder with our partners in health, housing, social care, the third sector, local businesses and communities, our supporters, staff, and volunteers – and most importantly, the people who rely on our services. Together, we can make Aberdeen a city where support is accessible, dignity is protected, and everyone has the opportunity to thrive.

We invite you to read this plan, share it, and join us on this journey. Change is possible and together, we can make it happen.

Donna Hutchison, Chief Executive Officer Alastair Bisset, Chair of the Board of Directors



## **Executive Summary**

#### **AMBITION**

To prevent homelessness and hospital admissions through a community-based, public health approach that addresses wellbeing disparities. By focusing on prevention and community support, we will reduce pressure on emergency and statutory services, improving wellbeing in the city.

#### **PURPOSE**

Aberdeen Cyrenians supports marginalised and vulnerable people, tackling housing and social issues, providing high-intensity drop-in support and integrated health and social care services. We work closely with stakeholders to raise awareness and empower people to make lasting, positive change.

#### APPROACH & PRINCIPLES

- Evidence-based alignment with local and national strategies.
- Partnership focus across public, private, and third sectors.
- Integration of lived experience into service design and delivery.
- Resilience through balancing service delivery with organisational sustainability.

#### STRATEGIC THEMES & GOALS

#### **01: PREVENTION & EARLY INTERVENTION**

We will expand upstream services, deepen our trauma-informed practice, and increase awareness of homelessness, focusing on those who are marginalised and vulnerable to reduce crisis and improve long-term outcomes.

## **02:** INTEGRATED HEALTH, HOUSING, SOCIAL CARE & EMPLOYABILITY

We will deliver holistic, wraparound support that meets people where they are – connect support pathways; develop multidisciplinary teams; expand high-intensity support hubs; and assist transitions from hospital, prison, or care to stable housing.

#### **03: EMPOWERMENT & INCLUSION**

We will co-produce services with people who have lived experience; foster peer-led initiatives, independence, confidence, and community belonging; provide life skills, and reduce digital/financial exclusion.

#### **04: COLLABORATION & SYSTEM CHANGE**

We will lead and participate in city-wide coalitions to influence policy with data and lived experience, align with Marmot City principles, and drive system change.

## 05: FOUNDATIONS FOR SUSTAINABLE SOCIAL CHANGE

We will invest in our people, digital systems, and research, retain and adapt services, ensure full cost recovery or planned subsidies, and diversify funding to ensure long-term resilience and evidence social value.

## Why it Matters – Tackling Inequalities in Aberdeen

Health inequalities in Scotland are avoidable, systematic, and deeply unjust.

The Health Inequalities in Scotland - First Report makes clear that these inequalities are not simply the result of individual choices, but stem from the social determinants of health - housing, income, education, employment, and access to services.

These factors combine to create poorer health and shorter life expectancy for many people, and they disproportionately affect those we support: people experiencing homelessness, trauma, substance use, or poor mental health.

In Aberdeen, the reality is stark. People living in our most deprived communities experience significantly fewer years in good health compared to those in more affluent areas. The risk of avoidable hospital admissions, reliance on emergency services, and long-term illness rises sharply for those facing housing insecurity or social exclusion.

That's why there's a pressing need for:

UPSTREAM INVESTMENT IN PREVENTION AND EARLY INTERVENTION

PLACE-BASED ACTION THAT RESPONDS TO LOCAL NEEDS

COLLABORATION ACROSS SECTORS TO TACKLE THE ROOT CAUSES

PARTICIPATION OF PEOPLE WITH LIVED EXPERIENCE IN DESIGNING SOLUTIONS

These principles are at the heart of our Strategic Plan.



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## **Statistics**





- People in the most deprived areas are twice as likely to experience poor mental wellbeing compared to those in the least deprived (p.17).
- One in three people experiencing homelessness also has a diagnosed mental health condition (p.17).



- People in the most deprived areas are three times more likely to be unemployed or economically inactive (p.20).
- 02. Low income is linked to increased risk of chronic illness, food insecurity, and housing



- Hospital admissions related to drug use are seven times higher in the most deprived areas compared to the least deprived (p.18).
- Alcohol-related harm is five times higher in the most deprived communities (p.18).



- There is a 13-year gap in life expectancy between the most and least deprived communities in the region (p.10).
- 102. Healthy life expectancy years lived in good health - is 20 years shorter for those in the most deprived areas (p.10).

## HOUSING &



- Poor housing is associated with a 25% increased risk of ill health and reduced life expectancy (p.14).
- People experiencing homelessness are six times more likely to attend A&E and four times more likely to be admitted to hospital (p.15).
- Rough sleepers have an average life expectancy of just 47 years almost 30 years shorter than the general population (p.15).

Sourced from 'Population Needs Assessment' report for Aberdeen. July 2025.

## **Our Purpose and Ambition**

ABERDEEN CYRENIANS IS FOR SOCIAL GOOD -PARTICULARLY HELPING THE MARGINALISED AND VULNERABLE

Aberdeen Cyrenians helps people in need, especially those who are struggling or left out by society.

We focus on:

- helping people find and keep a place to live
- offering a welcome space where people can drop in for support
- providing health and care services to improve people's wellbeing

We work closely with other organisations and use our combined skills and experience to raise aware about the issues people face, and support people in making lasting, positive changes in their lives.

#### **HOMELESSNESS**

- · Housing & Tenancy Sustainment
- Poverty & Crisis
- Digital & Financial Inclusion
- Gender Based Violence
- · Childhood Trauma & Abuse
- Liberation & Release
- Mental Health & Wellbeing
- Alcohol & Drug **Related Harm**

#### **WELLBEING INEQUALITY**

- Care at Home
- Granite Care Consortium

OUR SERVICES PREVENT HOMELESSNESS AND HOSPITAL ADMISSIONS THROUGH A COMMUNITY-BASED, PUBLIC HEALTH APPROACH THAT ADDRESSES WELLBEING DISPARITIES.

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This plan sets out how Aberdeen Cyrenians will work with partners across the city to prevent homelessness and unnecessary hospital admissions by addressing the root causes.

#### We will:



Embedding trauma-informed

problems escalating.

practice and early outreach to stop



#### **Work holistically**

Integrating housing, health, social care, and employability support.



#### **Empower communities**

Co-producing services with those who have lived experience, ensuring solutions are grounded in reality.



#### Drive system change

Using local data and lived experience to influence policy and funding, ensuring our city's approach reflects the needs of its people.

By aligning our work with the recommendations of the Health Inequalities in Scotland report, we are making sure our efforts contribute not just to individual recovery, but to a fairer, healthier Aberdeen for everyone. Our approach also reflects the priorities of Aberdeen City Council, Aberdeen City Health & Social Care Partnership, and the Scottish Government – with shared commitments to prevention, integrated health and housing, community empowerment, and tackling inequalities across the city and beyond.

## Strategic Themes and Goals

01:

#### **PREVENTION & EARLY INTERVENTION**

#### GOAL

Reduce homelessness and preventable calls on public services (such as hospital admissions and anti-social behaviour) before they occur.



#### **KEY ACTIONS**

- O1: Expand upstream services to prevent homelessness and calls on public services, with a focus on those who are marginalised and vulnerable.
- **02:** Strengthen trauma-informed practices across all services, particularly in early engagement and outreach.
- **03:** Through our community hubs, act as a trusted connector for marginalised and vulnerable people in relation to public health campaigns.
- **04:** Raise awareness of early signs of crisis and available support. These campaigns will be tailored to people experiencing crisis, agencies who support people facing crisis, and local community groups.
- **05:** Develop wider public understanding of hidden homelessness and other societal challenges, and their impact on people and society.



#### **IMPACT**

Reduces pressure on public services by improving long-term outcomes for vulnerable people.

#### **GLOSSARY**

#### **MARGINALISED:**

Focuses on exclusion and being pushed to the periphery of society (social, economic & political).

#### **VULNERABLE**

Focuses on being at risk and needing protection.

Those who are at a higher risk of harm, exploitation, or adverse outcomes due to their circumstances or characteristics. Can be temporary or permanent and can be due to physical, emotional, or social factors.

#### CRISIS:

Significant disruption or emergency situation that poses an immediate threat to health, safety, or wellbeing. It requires urgent intervention/immediate action to prevent further harm or damage.

#### INTERVENTION:

Involves actions taken to address and manage a crisis or problem that has already occurred. It aims to mitigate the impact, provide support, and resolve the situation. Responding and managing existing problems.

#### ISADVANTAGED:

Lacking economic, social, or educational resources and opportunities that others have, leading to poorer outcomes in health, education, employment and overall quality of life.

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02:

INTEGRATED HEALTH, HOUSING, SOCIAL CARE & EMPLOYABILITY

#### GOAL

Deliver holistic, person-centred care that addresses wellbeing – both health and social needs.



#### **KEY ACTIONS**

- Provide person-centred crisis and intervention support on behalf of statutory partners, integrating this into wider service provision.
- **02:** Continued development of multidisciplinary teams to deliver wraparound support (mental health, substance use, housing, financial inclusion, trauma) and link into the city networks and community partnerships.
- **03:** Expand high intensity drop-in support hubs to serve as access points for integrated care.
- **04:** Support transitions from hospital, prison, or care settings into stable housing with ongoing support.

#### IMPACT

Improves physical and mental wellbeing, reduces repeat crises, and supports holistic sustainable recovery.



#### **KEY ACTIONS**

- Ol: Co-produce services with people who have lived experience of homelessness, trauma, or marginalisation.
- **02:** Provide life skills, education, volunteering and employment pathways to support confidence building, belonging, and independence.
- **03:** Foster peer-led initiatives and community integration programmes.
- **04:** Support digital and financial literacy and access to reduce exclusion and dependency.

#### **IMPACT**

Builds confidence, independence, and a sense of belonging among those we support.



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04:

#### **COLLABORATION & SYSTEM CHANGE**

#### GOAL

Influence broader systems to create sustainable, long-term solutions.



#### **KEY ACTIONS**

- Ol: Participate and, where appropriate, lead in city-wide coalitions to address systemic issues.
- **02:** Use data and lived experience to influence policy and funding decisions, driving change locally and nationally.
- **03:** Align with Marmot City principles to address social determinants of health and wellbeing.
- 04 Be the trusted local partner for data, and the authentic voice, grounded in lived experience, on societal challenges.

#### **IMPACT**

Creates a more supportive ecosystem and drives systemic change for social good.

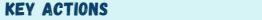


### 05:

## FOUNDATIONS FOR SUSTAINABLE SOCIAL CHANGE

#### GOAL

Ensure Aberdeen Cyrenians is a sustainable, resilient organisation capable of delivering long-term impact.



- Ol: Consolidate and retain existing services while adapting to changing community needs. Identify and pursue growth opportunities that align with mission and capacity. Strategically deploy our reserves to support innovation, resilience, and purpose-aligned initiatives.
- **02:** Develop workforce and volunteer capability, including training, wellbeing, and leadership development. Invest in infrastructure and digital systems to support service delivery and innovation.
- 03: Diversify funding through non-government contracts, social investment, and earned income. Ensure full cost recovery for services or implement planned subsidies where appropriate.
- O4: Support research and evaluation that demonstrates our social value and cost avoidance. Enhance organisational reputation with partners, funders, and the public through transparency, impact reporting, and engagement.

#### **IMPACT**

Strengthens organisational resilience, supports staff and volunteer development, and builds trust to enable long-term, purpose-driven impact.



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Journeys of Change

Every person we support has individual strengths, aspirations, and potential. Their stories show how the right support at the right moment can restore stability, rebuild confidence, and open the door to new opportunities. They remind us that change is always possible when people are valued, included, and not left to face crisis alone.

#### WILLIAM

Living alone with a heart condition, William was struggling with housing, bills, and isolation. At his lowest point, he attempted to take his life. By chance, he went to Aberdeen Cyrenians for a food parcel, and staff acted immediately, getting him to hospital. Since then, they've been a constant source of help – resolving housing and financial problems, assisting with complex forms, and always offering a listening ear.

"They never judge you, they sit and really listen to you and make you a cup of tea," he says. "If it wasn't for them, I literally wouldn't be here."



Photo: Centre for Homelessness Impact / Christopher James Hall Foundation

#### LILLY

Referred by her GP after years in an abusive relationship,
Lilly arrived anxious, isolated, and unsure how to begin again.
With her keyworker's support, she rebuilt her confidence,
made the brave decision to leave her partner, and took steps
towards independence – crafting a CV, finding work, and
reconnecting with her community.

"When I first came, I felt lost and disconnected," she says. "Now I've achieved every goal I set for myself and have a renewed sense of self."



Photo: Canva Pro Licensed by @dashapetrenkophotos

#### MARY

Severe anxiety and panic attacks left Mary virtually housebound, fearful of leaving her home and increasingly isolated. Working with her support worker, she started with small, achievable goals indoors, gradually building up to short walks outside. Within months she was attending appointments, visiting local cafés, and even meeting friends independently.

"What was once a pipe dream - socialising and enjoying life - has now become my reality,"
Mary says.



Photo: Getty Images via Canva by @Yarinca

#### BETH

Beth's home life became strained due to a lack of space and independence. After joining Care Choices, she set two goals: to live in her own home and improve her wellbeing. With support, she learned budgeting and household skills, secured her own tenancy, and began volunteering. She rebuilt her relationship with her family, established healthy routines, and now lives independently.

" I would not have been able to live in my own home if I didn't have the support from my team," says Beth. "I have reached my dream."



Photo: Canva Pro Licensed, by @Scopio

#### PAUL

When Paul arrived at Wernham House, he was homeless, and battling long-term alcohol and substance misuse. Trust in professionals was gone, and his health was in decline. Staff focused on safety and stability, offering essentials and a room of his own.

Through a managed alcohol plan and steady, person-centred support, Paul's health and confidence have improved dramatically.

"I finally feel safe," he says, "something I hadn't experienced in years."



Photo: Centre for Homelessness Impact / Christopher James Hall Foundation

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#### FOR FURTHER INFORMATION

