MAKING REFERRALS STAND OUT

Groundswell
Out of homelessness

City of Westminster

Change Communication

Contents

Acknowledgments

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Aims

- To help staff be aware of possible difficulties that could be encountered when making referrals.
- Provide suggestions on how to improve referrals e.g., a check list to consider, questions to consider, tips for explaining substance use.
- Provide information about the ISBAR technique.

Introduction

Creating successful referrals is hard. You will probably need to make referrals to numerous organisations; health services, safeguarding teams, social services, clearing house and the list goes on…Staff are not trained at how to make the 'perfect referral', so this toolkit can help as a starting point to making referral stand out.

What are the hurdles when making referrals?

It may be useful to complete a review to consider what the problems are when making referrals for the service you are working in.

Difficulties that could exist when making referrals may include the following:

- **Understanding the referral requirements** for the service. This can be made harder because on the whole thresholds are increasing due to a reduction in the number of resources available.
- It can be difficult for **staff to find the time to complete referrals** - especially if the referral form has several pages and requires lots of supporting information from medical professionals.
- An **accurate client case history can be difficult** for the client to provide e.g., when completing Clearing House and providing inaccurate housing history.
- **If a client is using a high level of substances**, their referral could be rejected from a service provider:
    - E.g., the falls prevention services will not work with those who fall due to using substances https://clch.nhs.uk/services/falls-and-bone-prevention-service. They may believe that someone using substances won't benefit from the input, but it can also be that they are not confident in working with this client group as they are not trained in working with those using substances at such high levels.
    - E.g., the Single Point of Access for mental health support won't assess clients experiencing a mental health crisis if their primary support need is substance use.
- Blame can be placed at the client's door. ***'If the substance use is dealt with first then their issues would go away!'*** Who makes the decision that substance use is the clients' primary support need or whether the level of motivation is the right level to work with their service? They may have a different way of measuring an individual's motivation to services that work with those experiencing homelessness, if a service does not work from a trauma informed perspective.
- Services may argue whether it is a mental health issue or a substance use issue.
- Support services that staff will deal with are under a lot of pressure, so it is beneficial to consider how we can help them.

<u>What else is going on for clients?</u>

- Complex health issues
- Emotional trauma
- Neurodevelopmental 'overlay' (something you are born with – developmental language disorder is a difficulty with language it means your brain thinks differently). E.g., if

someone has DLD and they are depressed, it will be more difficult for that individual to explain how they are feeling to get the help they need.

- A lack of insight might be apparent e.g., a brain injury will impact an individual's ability to reflect.
- Shame could be in the mix for a whole host of reasons e.g., being ashamed of their accent may prevent someone from speaking, especially if they feel someone else has a better accent than themselves. People want to be independent and therefore will hide their support needs as much as they are able to.

Where do we start?

When exploring referrals made by your service, it's a good idea to consider the following:

- It's a marathon, not a sprint. Take it slowly and make gradual changes.
- If the approach to referrals is altered – all team members will need to change their approach consistently.
- Staff members are not provided with training on how to make good referrals. When a new member of staff joins, get them to shadow a more experienced member of staff when they make a referral so they can watch and learn. Add this task to the staff induction list so it isn't forgotten!
- Speak to staff members and get advice on the best ways to share their knowledge on making referrals to services.
- When a referral is accepted, have a look at the referral form that was sent out and see if there is any learning to be made.
- Build relationships and understanding – you want to build a professional 2-way referral process so the organisation can come to you and let you know what is required. This means that you will also be able to point out where they have not met their referral guidelines and can flag this with them.
- Complain, but only if needed. You will need to think about the disadvantages / advantages of complaining. Can the issue be resolved informally, how much time will it take, would changing this one thing help many more people.

Build relationships with service providers.

It is recommended to build relationships with services you wish to refer to. Knowing someone in the organisation that you can discuss situations with can be beneficial.

Tips to build relationships include:

- Call them for an initial chat.
- Offer training / team meeting attendance.
- Ask what would help improve your referrals.
- Can you give them anything helpful? Service description, shadowing etc.

Get the basics right!

Making comprehensive referrals takes time in already busy schedules, so it's important to get the basics right. Below is a check list that you can go through to help ensure you don't waste precious time.

Things to consider before filling out a referral	Answer
• Why is the referral needed?	
• What is the criteria for the referral?	
• Have the needs of the client met the criteria for the referral?	
• Have you identified the correct needs of the client for the referral – could something else be the issue?	
• Generally, you will need to have consent to make the referral – or at least a good reason as to why you do not have consent. If referring to social services, and the client does not consent to the referral but does not have capacity or is self-neglecting, then you may want to refer to section 11: part 2 of the Care Act 2014 detailed here	
• Is it the right service to support/ refer to? Check what the referral criteria is. Check the inclusion / exclusion criteria before referring. **If your client hits one of the exclusion criteria, you will waste your time** (you can contact them to try and explore and change their stance on the exclusion criteria)	
• Do you have accurate medical information including physical health. Note that if referring to a mental health service you NEED to include physical health as it will be relevant. If you don't have this, are you able to get this if the client is registered with a GP?	
• If required explain the client's accurate ability in activities of daily living (ADL). Can they clean their room, cook a meal, get dressed? What is going on and can they manage their daily needs?	
• Send to right place (should the form be posted or emailed?)	
• Include full and accurate contact details (phone number/ email)	
• Ensure you can be easily contacted on the contact details you have provided (if the phone number you provide for the referring agency to get back to you on is always busy you may want to consider providing another number if possible)	
• Send the referral at right time (some services will only assess referrals every month – try and fit in with the demands of that service)	

Detective work – is there anything else that is relevant?

- Look at staff observations to see if there is anything else relevant e.g., go over your client notes. Keep an eye out for any patterns. When does the client disclose suicidal ideations? How many times have they said they feel suicidal?
- Ask the client their opinion about the situation you feel they need extra support for. For example, if the client is giving money to other clients for any reason, and you are worried about financial exploitation, ask the client how they feel about this. This easy read 'keeping your money safe' is a useful document to read with clients.

- Look back through notes to see what contact with other services the client has had. Are there any reports from these services available to read on the client's file? If not ask those services what their opinions/ thoughts are.
- Look back at the client's referral form and the interview form completed at your service in case there is anything you can include in your referral.

Question everything

- Is the information accurate?
- Is the information consistent? Could looking at CHAIN help (e.g., look at the support needs and whether there are considerable variations in how workers record the needs of clients?
- Has anything changed? For instance, watch out for any inappropriate recycling of labels! E.g., someone being reported as aggressive/ suicidal 5 years ago.
- Has the motivation of the client changed over time? If they have stopped using drugs and are still drinking, tell the service that they have successfully stopped using drugs, but are working on their drinking.
- Consider the role bias and discrimination may play (e.g., harder for women to get a diagnosis of autism due to being socialised differently and can hide their communication needs):
    - Consider the recorder perspective. When the information was recorded what was the knowledge base of the recorder? Did the person who wrote something take something on face value? For example, if a psychiatrist said it may be a learning disability – this does not mean they client has been diagnosed with a learning disability.
    - Consider your own unconscious bias and how they could be impacting the referral
- You may want to ask the client / their family and friends view of the information? For example a client might say they had an armed forces background, but they may be confused and a friend might be able to clarify.

Ask unusual questions!

These could be questions that you either ask the client, or consider yourself, to find out more about what may be behind the need for a referral.

If you think any of the following questions reveal relevant information, then add to the referral and explain why it is relevant.

Questions that you can consider:

Question	
What conditions commonly co-occur? What diagnosis may go with another diagnosis?	e.g., ASD and ADHD, lung conditions/ poor respiratory health and difficulties with communication, UTI, and urinary incontinence. Brain injury and communication issues.
What conditions may be linked others?	e.g., schizophrenia may be linked to cognitive issues. Individuals with schizophrenia (and when hearing voices) could display cognitive issues. They may find it more difficult to communicate.

Question	
What mental health conditions might be labelled as something else?	e.g., complex trauma diagnosed as personality disorder
Do the timings work in the client's case history/timeline? Are there gaps?	What was going on in the gaps (prison, living in accommodation)?

Questions for the client

It is important to ask the client questions about what they think before making referrals, as they may be reluctant to divulge the information on their own accord. Consider who is the best person to ask the questions?

Question	
When did the problem start? What else was happening at that time?	E.g., when people have started to sleep rough it could be that the issue that made them homeless started before they became homeless e.g., drinking, breakdown in relationship, chucked out)
What was school like? Was it easy to read and write?	This could flag up issues started much earlier than you considered.
Did you have any accidents or illness earlier in your life?	E.g., Head injury can see major changes in the individual's behaviour. You can read more about brain injury in homelessness settings here.
Was there a time they spent a long time in hospital? Does the client suffer from any hereditary conditions? Did parents, brothers, sisters have it?	Some conditions exist in families that can be a long-term condition. You can flag with service if there is a familial pre-disposition to a condition. e.g., in some cases mental illnesses may have genetic links.

Language matters

The words and language used in the referral will have an impact, so choose them carefully. Also hold in mind that the client can also read the referral if they wish as the referral will be in their file.

- Use professional language.
- Do not exaggerate.
- Explain what you have witnessed 'I've noticed that this person presents with (describe behaviour etc). The NHS website lists similar symptoms in XXX and so we have referred to you for further investigation – you can check symptoms of conditions at the NHS conditions webpage for accurate information about symptoms .
- Avoid judgement and emotional blackmail.
- Use the correct terminology for conditions.
- If at times the client is aggressive, you will need to explain this, but again choose your words carefully. Provide examples of the aggression, what you've seen and heard,

frequency and context of aggression. Explain what triggered the aggression (e.g., something that happened / feelings of disappointment / shaped by hallucinations, confusion or misinterpretation / affected by their perception of the environment or the behaviour of others). Consider their history and include any experience of abuse or trauma. You could use the term challenging behaviour as opposed to aggressive. See appendix 1 for a safety plan that can be used to help plan behaviour changes.

Think carefully about how you describe drug and alcohol use

- In referrals you could state substance use is a *'coping mechanism for considerable distress in the context of a lack of accessible alternatives'* You could include that *'I am fearful of the distress they would experience if they reduced their substance use whilst waiting for support.* Explaining this could be very useful for referring into mental health services who exclude individuals that are using substances.
    1. Be specific about use and whether substance use has changed recently. Has it gone down, then say that as there is change happening.
    2. State if substance use support is provided and accessed.
    3. State if you will help the client stay dry for assessment.
    4. State if you will attend assessment and ensure the client is present.
    5. State if issues always present or worse / better over time and behaviour change over time. If worse, try and identify what caused this (e.g., losing a key worker could impact a client's behaviour).

ISBAR Method

The ISBAR is a method to that helps provide accurate and full information in a time efficient way with a clear request for assistance. It is useful to in time pressured environments because it keeps the message and request concise. Use the ISBAR headings in the information you provide to provide clear information and be explicit about your request.

It can be useful to use the ISBAR headings for each section of information. Ensure you keep each section short and to the point – you can always refer to detailed reports in appendices.

HEADING	EXPLANATION	EXAMPLE
INTRODUCTION	Who you are, who you work for and what your role is.	Introduce yourself, include all relevant contact details.
SITUATION	What is happening at the moment.	X is 45-year-old woman, rough sleeping, hearing voices etc.
BACKGROUND	What led up to the current situation.	e.g., family, health, and housing history etc.
ASSESSMENT	What is your view of the situation and the client's view.	- experiencing mental illness, client expressing suicidal thoughts. - current risks with evidence - what support is needed?

HEADING	EXPLANATION	EXAMPLE
REQUEST	What you would like the organisation to do.	Make your request (put in red/bold?), state law if you know it (key phrases) e.g., assessment for appointment.

When you hear back about referral

There's always a chance you don't hear anything back. If you don't hear anything back, you should send the referral again and call them up and chase your referral. Don't assume they have received it, just because you have sent it.

<u>If it is a yes</u>

1. Respond with thanks.
2. Support appointment making.
3. Check and explain requirements for assessment.
4. Prepare client.

<u>If it is a no</u>

1. Respond with thanks for considering.
2. What was the reason for refusal?
3. Consider appealing.
4. Ask who they think may be an alternative service or alternative ideas.
5. Explain the issue to the client and a plan for future.

Further reading and resources

Homelessness and brain injury toolkit https://groundswell.org.uk/wp-content/uploads/2020/10/Brain-injury-Toolkit-June-2018-1.pdf

How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Safeguarding-guide-final-August-2021.pdf

Identifying and working with self-neglect in people experiencing homelessness https://homelesshealthnetwork.net/wp-content/uploads/2023/07/Self-neglect-guidance-July-2023.pdf

Learning disabilities and homelessness https://groundswell.org.uk/wp-content/uploads/2022/05/Learning-Disabilities-Toolkit-.pdf

Westminster HHCP's Adult social service referral toolkit https://groundswell.org.uk/wp-content/uploads/2021/08/HHCP-Adult-Social-Services-Referral-toolkit.pdf

Westminster HHCP's safeguarding contact sheet https://groundswell.org.uk/wp-content/uploads/2020/10/Westminster-key-safeguarding-contacts.pdf

Appendix 1 - Safety plan

Risk to others (to be completed collaboratively with the person being supported)

What are the main triggers for anger or violence?	
What steps can be taken to avoid or prepare for these triggers?	
If I do become agitated and angry, how would I like people around me to behave, e.g., Leave me alone and give me space or talk to me?	
What are the strategies that have helped in the past?	
Can I learn and practice new strategies?	
Immediate action needed to keep myself and people around me safe.	

Safety planning – risk to self (to be completed collaboratively with the person being supported)

Main current risks and warning signs / triggers.	
Coping strategies that have helped in the past?	
What is the most helpful approach from people around me?	
People that I know whom I can ask for help and support.	
Immediate plans to ensure safety.	

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