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| **STEP Service**  **Referral Form**  Clients referred to the STEP service should meet ALL the following criteria:  **Criteria 1:** The client is rough sleeping/in the rough sleeping pathway in the borough of Westminster. Priority will be given to T1000 and high intensity user clients. Additionally, rough sleepers who regularly move between Westminster and Camden can also be considered.  **Criteria 2:** The client has suspected mental health issues that either do not fit the criteria for the CMHT or the HT; OR who have history of multiple unsuccessful engagements with standard pathways (often these clients will have fallen through the gaps repeatedly). Further, they will likely have drug and alcohol issues and face multiple disadvantage and complexity or co-morbidity.  **Criteria 3:** The referral is received from a professional service such as:  Homeless outreach services in Westminster and Camden (SOS, SET, SIT)  Homeless day centres  Homeless GP  EASL; Repatriation Hostels; Neighbouring Homeless MH (FOCUS/START)  Drug and alcohol services in Westminster  Accommodation Providers  Psychology in Hostels (incl. Homeless Neuropsychology Pathway)  **Criteria 4:** The referral should be made jointly or made by more than one service (this is because as stated in criteria 2, the emphasis on access to the STEP pathway should be based on unsuccessful service input, to promote service integration and joined-up care planning across the network). If this is not possible, it should be explained in the referral.  **Criteria 5:** The referral should not fall into any of the exclusion criteria which are:  Open to a CMHT already  Standard services not already tried  If it is not primarily mental health or suspected mental health  Already assessed by STEP service and no change in circumstances  **NB. If the referral requires urgent attention or it is out of hours, please call the SPA on 08000234650**  **Duty email for STEP:** [**cnwl.step@nhs.net**](mailto:cnwl.step@nhs.net)  **If information is section is unknown, please just make a note of this in the relevant section.** | | | | |
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| **Referrer information** (referrals should be made by more than 1 service) | | | | |
| **Referrer(s) name(s):** | | | **Referrer(s) service(s):** | |
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| **Referrer(s) email(s):** | | | **Referrer(s) phone number:** | |
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| **Other services the client is open to:** | | | **Contact details for the other services:** | |
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| **Initial discussion had with STEP service duty?** This is mandatory before making a referral | | | **If so, what was their name and when did you speak to them?** | |
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| **Client information - demographics** | | | | |
| **Given name:** | | | **Family Name:** | |
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| **Also known as:** | | | **DOB:** | **Gender:** |
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| **All languages spoken and preferred language:** | | | **Interpreter needed?** | |
|  | | | **Yes: ☐ No: ☐** | |
| **Ethnicity:** | | **Nationality:** | **Religion:** | |
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| **Are they from Westminster?** (This is an essential referral criteria) | | | **If so, do you know for how long?** | |
| **Yes: ☐ No: ☐** | | |  | |
| **Are they on the rough sleeping pathway?** (This is an essential referral criteria) | | | **If so, do you know for how long?** | |
| **Yes: ☐ No: ☐** | | |  | |
| **Is this person an identified T1000 or High Intensity User client?** | | |  | |
| **Yes: ☐ No: ☐** | | |  | |
| **Mental health information** | | | | |
| **Do they have suspected or diagnosed mental health conditions and if so, what?** | | | | |
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| **Are they already open to a community mental health team (CMHT)?** Clients referred to the STEP service should not be open to the CMHT, if they are, please explain why you think input from the STEP service is required. | | | | |
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| **Have they been open to a CMHT in the past?** Please provide times, dates and names of services if known. This should include admissions and if they have been detained under the mental health act. | | | | |
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| **Drug and alcohol information** | | | | |
| **Do they use substances and if so which ones?** | | | | |
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| **Which drug or alcohol services have been or are involved?** | | | | |
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| **Other service input** | | | | |
| **What input has the client had from other services?** (e,g, homeless services, housing, EASL, Psychology in Hostels Team, criminal justice/probation services, adult social care) | | | | |
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| **Are they registered with a GP?** If yes, plrease provide the name of GP and practice, NHS number and please state if they are known to Great Chapel Street or the Homeless Health Team | | | | |
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| **Reason for referral** | | | | |
| **What are the current concerns about this client?** | | | | |
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| **Why has previous service input not been sufficient for this client?** (for example, disengagement, difficulties finding the client, complexity of presentation etc). | | | | |
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| **Has anything helped or worked for this client in the past?** | | | | |
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| **What are the clients’ strengths/interests or values?** | | | | |
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| **Is the client aware of this referral? If no, please explain why** | | | | |
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| **Client information – background** | | | | |
| **Risk factors – harm to others or harm to self** (please consider any aggression, self-harm, any vulnerability; children/minors; other people around; unsafe sleep site etc; any stays in hospital/prison; any issues of domestic violence/offences/ASBOs) | | | | |
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| **Relationships** (family and others, including concerning relationships) | | | | |
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| **Physical health issues** including any relevant medical history | | | | |
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| **Brain injury or neurodevelopmental conditions and cognitive deficits** (e.g., autism, attention deficit hyperactivity disorder) – including head injuries (e.g., from an accident/blow to the head/fall), neurodegenerative conditions (e.g., dementia). Cognitive deficits may include difficulties with thinking skills such as memory, concentration, planning etc). | | | | |
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| **Description** (what are they wearing? What is the colour of their hair, eyes and skin? What would you say their heigh and weight is? Are they are any distinguishing visible marks/scars? Do they have an obvious accent?) | | | | |
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| **Client information - accommodation** | | | | |
| **Please include accommodation history if known** (how long have they been street homeless in Westminster? Attach housing history if available. | | | | |
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| **When and where did they last have accommodation?** (what happened? Why are they homeless? Include – last settled base and reason for leaving; where they have been in the past three months) | | | | |
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| **Do they still have accommodation somewhere?** If so, please give details. | | | | |
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| **Likely places to find them, including times** (including current sleep-site and bedded down/wake up times) | | | | |
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| **Do they attend a day centre? Is there a pattern of attendance?** | | | | |
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| **Client information – other background information** | | | | |
| **What ID do they have?** | **Has the ID been seen?** | | **CHAIN number:** | **Date verified:** |
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| **Do they have benefits or income?** | | | **If yes, what?**  **If no, are they entitled to claim?** | |
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| **National insurance number:** | | | | |
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| **Date of first entry into UK:** | | | **Date of last entry into UK:** | |
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| **Foreign nationals:** | | | **Status:** | |
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| **Immigration status details (including date visa ending):** | | | | |
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| **Last local connection:** | | | | |
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| **Date of the referral:** | | | | |
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Please send this referral to cnwl.step@nhs.net

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| **For ADMIN purposes in the STEP service only** | |
| Date referral received |  |
| Action taken: |  |