

CLEARING HOUSE

Referral Form Minimum Standards



Monitoring

This guidance is reviewed every two years or in line with service changes, whichever comes first.

1. Introduction

1.1. The information submitted in the online Clearing House referral form is used by the Clearing House to assess the eligibility and suitability of clients for accommodation via the Clearing House service.

As well as being completed by referral agencies, TST workers complete the same form when submitting a transfer request for a current RSI tenant.

1.2. Consider that the information that you provide in the referral form will be seen by the housing provider and the TST team when the client is nominated to a property. This will be the only information they receive at the point of nomination, therefore it is essential that referral forms are clear, detailed and consistent in standard and that information provided is clearly evidenced.

1.3. Referral workers (or TST workers with a client on the waiting list for a transfer) are responsible for updating the Clearing House via the online system with any change in the client's circumstances that may impact on their housing need.

2. Aim

2.1. This document is intended for staff who have access to the online referral system and as such will be of limited use if you do not yet have access. To gain access contact the Clearing House Helpdesk on 020 3856 6008 or ch@mungos.org.

2.2. Ensure the completion of referrals and transfer requests to the required standards at the first attempt and to reduce the number of referrals that are returned to referral agencies and TST teams for further information and clarification. This will improve the experience of all users of the Clearing House and improve the speed at which clients can be rehoused.

3. Getting Help

For help and advice about this document or in completing a referral form or transfer request please contact a member of the Clearing House Team on 020 3856 6008 or email ch@mungos.org.

4. Related policies, references and forms

- Referral and Waiting List Policy & Procedure
- Transfers Policy & Procedure

5. Before you start

It is best practice that you complete the Pre-referral Client Information Session with your client before starting a referral form. The information session is a PowerPoint document that can be found in the Clearing House Library on the Clearing House website, most easily reached through the Quick Links in the left-hand sidebar. It gives details on what Clearing House offers and the expectations of the client (such as engagement with TST and support services).

6. Guidance for each section of the referral form

6.1 Create a new client record

If your client doesn't already have a record on our system you will need to create a record for them. This screen is self-explanatory, but very important. It is essential that the information entered here (and in any part of the form) is correct. This information is used by Clearing House to help verify the eligibility of the client for the service (see section 2).

- Return to original documentation (such as passport or birth certificate) when inputting the personal information for this section. Errors are often copied from one system to another, so returning to source documents is important to ensure that referrals can be processed quickly.
- If you are unsure of the client's CHAIN number you will need to speak to the CHAIN team. If you contact CHAIN with your client's full name and date of birth, they will be able to confirm their CHAIN number: 020 3856 6007 or ChainHelpdesk@mungos.org.

6.2 Referral Form

Eligibility Criteria - this section contains four questions to which you and your client must be able to answer 'yes', with your client making an informed decision

Couple Referrals – only complete this section if the client intends to live with their partner. If you are not also referring the partner it is even more important that you provide details about them here including whether they have any vulnerabilities, the impact of the relationship on your client and any risks.

Information – if your client does not have any ID we will not be able to accept them onto the waiting list as housing providers have to adhere to this government guidance: <https://www.gov.uk/government/publications/right-to-rent-document-checks-a-user-guide>

Worker contact details – if at all possible please provide an additional referral contact for any times when you may be unavailable.

6.3 Housing history

- The last five years of the client's housing history must be provided and must be as accurate as possible, there should be no gaps in the history - although we understand some dates may be estimated and some addresses not fully remembered by the client.
- Don't make a complete guess; if the client cannot remember at all, please state this in the housing history.
- On the record for their current address ensure you tick the 'current address' box and select 'Still resident' in 'Reason for Leaving'.
- If your client has previously been referred to the Clearing House you will find the Housing History window will already contain some entries. You will not be able to edit these. If anything is incorrect or incomplete e.g. lacking an end date or an address please call or email us to provide the information.

6.4 Assessments

Clearing House requires details relating to past and present support needs so that clients can be assessed in order to understand the level of on-going support they may need in their own property and to share insights around management strategies, triggers and warning signs that will help the TST to support your client.

6.4.1 Alcohol use

If your client is currently or has previously been a problematic drinker you must provide details. Please give a detailed overview of your client's drug use history – what has been their journey up to this point including details around their engagement with services, past treatment (such as detox or rehabilitation) and any cycles or periods of abstinence/reduction and relapse.

When providing details in the text box please consider the following:

Details of alcohol use:	Engagement with services/treatment:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What, how much and how frequently did your client used to drink? • For how long did they drink at previous levels? • If they have previously managed periods of abstinence/reduction followed by (re)lapse please give details. • What is different this time? 	<ul style="list-style-type: none"> • If the client is engaged with support/treatment around their alcohol use what is the frequency and nature of this support e.g. 1-2-1 counselling, groups etc.? • If they are not engaged, why is this? • If the client is currently abstinent or has managed periods of abstinence in the past, how did they achieve this? 	<ul style="list-style-type: none"> • What are the triggers to relapse/increased drinking? • How does their alcohol use impact on their behaviour and ability to manage a tenancy now and how has it impacted in the past? • What strategies do they have for maintaining abstinence/reduced levels of drinking? • What on-going support will they require from the TST around this?

Example 1:

Ann is alcohol dependent and currently drinks on a daily basis. She usually drinks cider, approximately four cans (500ml each) a day of White Ace (9%ABV, 18 units per day). Ann is 35 and has been drinking this heavily for the past 5 years since she became street homeless after being evicted from her deceased mother's council tenancy.

Ann has previously engaged with support around her drinking and approximately 6 months ago completed a residential detox. Through engagement with the community alcohol service (one-to-one counselling and group session) Ann was able to reduce her drinking in preparation for detox. However, Ann discharged herself three days into the detox stating that her sister was ill and that she needed to go and see her. Ann's drinking returned to its current levels (see above) and she has not been meaningfully engaged with alcohol services since.

Ann's drinking can be triggered by issues around her family, for instance when her mother died and she was forced to leave the property; Ann began to drink heavily. When Ann's sister became ill, she discharged herself from treatment and began drinking again. Ann can be easily influenced by other drinkers and will often associate with other street drinkers outside of the hostel.

Example 2:

Ann has been alcohol dependent since she was 30 and came to our housing service six months ago after completing a two week detox and 12 weeks of residential rehabilitation in Norfolk. Since moving in Ann has engaged well with aftercare services and support with the community alcohol service; attending therapeutic groups as well as receiving ETE support from the service.

At least twice each week Ann attends AA meetings locally and does this particularly to help keep her time filled or when she is feeling low. At present Ann will need to ensure she is well occupied to support her recovery and must maintain engagement with community alcohol services and support.

Prior to her treatment Ann was drinking about four cans of White Ace (9%ABV) daily for around 3 years. This period of drinking followed a relapse after managing abstinence for 3 months. Ann's current period of abstinence is the longest period she has experienced and is strengthened by having attended rehab, which she had not done before. Ann's relapse 3 years ago was triggered by family difficulties and there continues to be an increased risk of lapse/relapse if Ann's relationship with her family members becomes strained. Ann has found discussing her family issues during keywork meetings very helpful, and any support worker taking on Ann's case should ensure this continues.

Current alcohol use - Use the specific questions to provide basic details about your client's current drinking levels or abstinence. This is just a snapshot – full details should have been provided in the text box above.

Treatment – Your answers in this section should reflect the current period of your client's engagement with alcohol support. Dates and time periods given should refer to current, continuous engagement e.g. if they first engaged with the service 2 years ago, but disengaged for 6 months and have now only been reengaged for 3 months then the answers should refer to when they reengaged. You can include detail about previous periods of engagement in the text box above.

Worker details - You must provide the name and contact information for the client's current support service or treatment provider. This information is important in ensuring the transition of a client's care and support from one service to another and facilitates communication between support and treatment providers.

6.4.2 Area selection

- Your client must select a minimum of three London boroughs. However some boroughs contain no or very few RSI properties and therefore do not count towards the minimum three. These boroughs are: Barking & Dagenham, Bexley, Bromley, City, Croydon, Greenwich, Havering, Kingston, Redbridge, Richmond, and Sutton. You may select these boroughs, but must also choose three other boroughs.
- If your client is unable to select three boroughs you must provide detailed reasons as to why e.g. if the client is a registered carer for another person and need to be housed close by.
- If there are specific areas where a client is unable to reside within their chosen boroughs these must be listed along with detailed reasons as to why.
- You must select **all** floor levels and property types (e.g. studio or 1 bed) that your client is able to accept and provide detailed reasons for any restrictions.
- If your client has a pet this must be declared in this section giving details about the type of pet.
- Please provide any additional information relating to the client's housing requirements and include clear reasons as to why.

6.4.3. Finances

If your client has ever had issues with financial skills you must provide detailed information in the text box – this includes if they have arrears/debts, a history of irregular payments, a history of discontinued benefits or are not receiving all entitled benefits. Please consider the following:

Details of Finance & Budgeting SNs:	Support, triggers, tenancy issues:
<ul style="list-style-type: none"> • If your client is not receiving all entitled benefits please explain why. • If your client has a history of discontinued benefits please give details including what impact it has had, what support they need around this and how this risk is now managed. • How well do they manage their money and budget for bills and service charge? 	<ul style="list-style-type: none"> • If your client has arrears and/or debts please provide details of how they were accrued and if there have been specific triggers that have caused this to happen. • How might the client's level of skill around financial matters impact on their tenancy? • What impact, if any, has it had in the past? • What on-going support will they require from the TST to maintain their tenancy?

Income

- Select **all** benefits your client is receiving including Housing Benefit where appropriate.
- 'Average weekly income' should only include any legitimate, personal income i.e. it should not include Housing Benefit or any cash-in-hand work.

Arrears and Debts - This section is generally self-explanatory. If your client has other debts besides current rent arrears please give details of the debt in the text box 'Details of debt reduction', including how much they owe and to who, how much they are repaying and how often or what reasonable attempts they have made to set up a payment plan. Past rent arrears that are still owing should be included here under 'other debts'.

Gambling

If your client has ever had an issue with gambling you must provide details about both the past and present in the 'Gambling details' box. Please consider the following:

Details of gambling:	Engagement with services/treatment:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What type of gambling did they used to / do they engage in and how often? • If they have stopped gambling, but have previously (re)lapsed please give details. What is different this time? 	<ul style="list-style-type: none"> • If the client is engaged with support/treatment around their gambling what is the frequency and nature of this support e.g. 1-2-1 counselling, groups etc.? • If they are not engaged, why is this? • If the client is currently not gambling or has managed this in the past, how did they achieve this? 	<ul style="list-style-type: none"> • What are the triggers to relapse/increased gambling? • How does their gambling impact on their finances or ability to maintain a tenancy now and how has it impacted in the past? • What strategies do they have for managing their gambling? • What on-going support will they require from the TST around this?

6.4.4 Mental & Physical Health

Mental Health

If your client has a mental health diagnosis, has had a mental health support need in the past or you suspect that there may be an undiagnosed mental health support need, you must provide details.

Details of the client's mental health diagnosis:	Engagement with treatment and services:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What is the client's clinical mental health diagnosis? • When were they diagnosed? • If you suspect mental health issues what do you consider these to be? • What behaviours lead you to suspect the client may have a mental health issue? 	<ul style="list-style-type: none"> • What treatment does the client receive and who from e.g. counselling, medication? • Give details of any periods when they have not been compliant with treatment. • How do mental health issues impact on the client's engagement (i.e. withdrawal, isolation, disengagement with support)? • If the client is not engaging with support or treatment how does this impact on them? • Is the client currently under a Community Treatment Order? 	<ul style="list-style-type: none"> • What specifically triggers deterioration in mental health for the client? • Does the client's mental health impact on their ability to manage their tenancy (i.e. addressing bills and letters, seeking help and support)? • Does the client struggle to care for themselves (i.e. personal care, self-neglect)? • What on-going support will the client require from the TST or elsewhere to maintain good mental wellbeing? • What warning signs, indicating the client's mental health may have deteriorated should the TST be aware of?

Example:

Tony has a diagnosis of paranoid schizophrenia and was diagnosed when he was 23 (he's now 41). Tony has engaged very well with the CMHT and visits his Psychiatrist every three months and is visited at his flat by his CPN every fortnight; Tony always keeps these appointments and likes his CPN.

When unwell, Tony experiences auditory hallucinations (voices) and persecutory delusions. He will believe people, often family members, are plotting against him. Tony will withdraw socially, neglect his personal hygiene and can become agitated.

Tony takes Olanzapine orally (20mg each day) and has been doing so for the last six months without any issues. Prior to this, Tony had received depo injections each month for his medication. Tony prefers tablets (over the injections), but it can sometimes make him quite drowsy and he can find doing anything strenuous after taking them difficult. On some occasions Tony has missed appointments because he has fallen asleep after taking his medication.

Tony requires some prompting to keep his flat tidy and needs reminding to vacuum his flat. Tony sometimes listens to his wrestling tapes very loud which has disturbed his immediate neighbour. Tony has needed reminding to keep the noise down and he was assisted to buy some headphones, but sometimes needs reminding to use them.

Tony has previously self-medicated with crack and cannabis and proximity to significant drug use could prove problematic for him. If Tony starts to use drugs, he is likely to stop taking his medication and withdraw from support; he can become quite distressed and agitated presenting auditory and visual hallucinations. Tony will likely struggle to keep his flat clean, his personal care will deteriorate and he will stop paying his service charge and utility bills. This will usually lead to a period of hospitalisation.

Tony will need on-going support from the local CMHT as well as visits fortnightly from his CPN to support him in maintaining his medication and engagement with support services. Should Tony disengage from support or present as paranoid it is recommended that CMHT be notified immediately.

Learning disability

If the client has a learning disability you must provide details in the text box.

Details of the client's learning disability diagnosis:	Support, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What is the client's diagnosis? • When were they diagnosed? • If you suspect a learning disability what do you consider it to be? • What leads you to suspect the client may have a learning disability? 	<ul style="list-style-type: none"> • Please give details if this issue causes the client difficulty in maintaining a tenancy, carrying out day-to-day living or engaging with support. • Without support, how would this issue affect the client? • Provide details of any engagement with support the client has and on-going support they will require from the TST or elsewhere.

Physical health

If your client has a significant physical health issue, or has had a physical health support need in the past that will impact on their ability to support themselves and maintain a tenancy, you must provide details.

Details of client's physical health diagnosis:	Engagement with treatment and services:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What are the client's health issues and when did they start (diagnosis and prognosis)? • If you suspect there are undiagnosed health issues, please give details. Why do you suspect this? • How might the client's health needs be met in their own flat – e.g. do they require mobility adaptations to the property or ramp access? 	<ul style="list-style-type: none"> • What treatment does the client receive and who from? • What medication does the client receive and are they compliant with it? • If the client is not engaging with support or treatment how does this impact on them? • Does the client have a visiting or live-in carer? 	<ul style="list-style-type: none"> • What specifically triggers deterioration in physical health for the client? • Does the client struggle to care for themselves due to physical health needs? • What on-going support will the client require from the TST?

Example:

Phil walks with a severe limp and uses a stick to assist him in getting around. He requires a hip replacement operation (right hip) due to serious damage caused by arthritis which has been significantly worsened by several years of rough sleeping. Phil is assessed as requiring a hip replacement but historically there have been some issues in this procedure being completed due to Phil's very high levels of alcohol and heroin use – although this is now much reduced.

Phil is prescribed painkillers and anti-inflammatory medication to help manage the discomfort which he manages to take himself with no issues. Phil will require a property on the ground floor as he is unable to easily manage even a small number of steps.

Phil risks damaging his hip further when he drinks, as he is likely to go out more without his stick and when drinking will sometimes sleep rough instead of return to the hostel.

Medication – you do not need to include substitutes like Methadone here, this will be covered in the Substance Use assessment.

6.4.5 Substance Use

If your client is currently, or has previously, used street drugs (including abusing prescription medication or street methadone) you must provide details. Please give a detailed overview of your client's drug use history – what has been their journey up to this point including details around their engagement with services, past treatment (such as detox or rehabilitation) and any cycles or periods of abstinence/reduction and relapse.

Details of the substance(s) used and how:	Engagement with services/treatment:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • What, how much and how frequently does your client use now? How long at this level? • What, how much and how frequently did your client use in the past? And for how long at those levels? • If they have previously managed periods of abstinence/reduction followed by (re)lapse please give details. Is there a pattern to this? • What is different this time? 	<ul style="list-style-type: none"> • Is the client compliant with prescribed substitutes? • Have there been periods in the past when they have not been? • If the client is engaged with support/treatment what is the frequency and nature of this support e.g. 1-2-1 counselling, groups? • If they are not engaged, why is this? • If the client is currently abstinent or has managed periods of abstinence in the past, how did they achieve this? 	<ul style="list-style-type: none"> • What are the triggers to relapse/increased use? • How does their drug use impact on their behaviour and ability to manage a tenancy now and how has it impacted in the past? • What strategies do they have for maintaining abstinence/reduced levels of use? • What on-going support will they require from the TST around this?

Example 1:

Connor began using cannabis when he was a teenager. When he was 25 he was introduced to crack by a friend and used it occasionally before becoming a regular user. A couple of years later he tried heroin and his life began to spiral out of control. At its worst (35 years) he was using £400 of crack and heroin a week and injecting. When Connor was using heavily he had problems with anger management and has convictions for common assault and ABH from this time (see Risk Assessment for more).

After his ABH conviction he knew he had to make a change and started working with services. He got onto a script and over time worked on the causes of his addiction. He reduced his use, stopped injecting and attended detox and rehab in 2013. After leaving rehab Connor remained abstinent for a year, but relapsed on heroin in March 2015 when a close friend died. However he didn't return to using crack and or to his previous levels of heroin use, but was instead smoking 2-3 times per week. After an initial period of difficulty he linked himself back in with services and went back on a script. Currently he smokes approx. once a fortnight (a bag/£10 each time) on payday. He has been using at this level for about 6 months. He is currently scripted (methadone 30ml, reduced from 70ml).

When Connor was using a lot before rehab he lost accommodation on a number of occasions due to prioritising his using over paying his rent. When he relapsed he did have some initial trouble paying his service charge because he also started associating with other users and struggled to engage with the service. However since June 2015 he is not associating with other users and is focused on treatment and paying regularly.

Connor is really motivated to stop using on top so he can reduce his script and become abstinent again. He has been seeing a psychiatrist for 3 months separate from the counselling he has at CGL and is finding this really helpful. This is new for him and makes his chances of relapse much lower. He has a positive network of friends and is volunteering once a week, all of which helps him in his recovery.

Connor's main triggers are feeling isolated, being around other users and memories of abuse he experienced as a child however he is addressing this with his psychiatrist and has developed strategies to change his thinking when this occurs.

Support from TST: helping him to link in with a drug service and continuing to encourage and support him in finding activities and volunteering opportunities. The warning sign that Connor may have begun increasing his use is that he begins to isolate.

Substance misuse – current and past - Use the specific questions to provide basic details about your client's substance misuse, including how much they currently spend and how long they have been using at this current level or been abstinent. Please **tick all substances that they have used**, even if they no longer use them – in this instance you can select 'abstinent' for frequency. This is just a snapshot – a full overview should have been provided in the text box above.

Substance misuse support

- Your answers in this section should reflect the current period of your client's engagement with alcohol support. Dates or time periods given should refer to current, continuous engagement e.g. if they first engaged with the service 2 years ago, but disengaged for 6 months and have now only been reengaged for 3 months then the answers should refer to when they reengaged.
- You must provide the name and contact information for the client's current support service or treatment provider. This information is important in ensuring the transition of a client's care and support from one service to another and facilitates communication between support and treatment providers.

6.4.6 Additional Support Needs

Independent living skills (ILS)

If your client has ever had difficulty with independent living skills you must provide details, but if they have only ever managed this well then this is still helpful to know. Please consider the following:

Details of support needed, past and present:

- Please give details of any difficulties your client has had managing the tasks/areas indicated.
- Have there ever been issues with safety in the kitchen e.g. leaving the gas on?
- If the client is / has been known to hoard, please provide details.
- Is the client able to contact the landlord or support worker to report maintenance issues?
- How might the client's level of skill in independent living impact on their tenancy?
- What support is currently needed from their support worker and will be needed from TST in these areas?

Education, Training and Employment (ETE)

Where appropriate, give details of your client's future plans to engage in work, education, or training, and any support they may need around this or improving their essential skills.

Legal History (criminal offending)

Clearing House will need to be informed of your client's offending history and criminal convictions. It is important that we are aware of offences including, for example, violence against other people, sexual offences and arson so that the client can be appropriately housed. Does the client have upcoming court dates or are they due for sentencing; are they likely to serve a custodial sentence?

Details around the client's offending behaviour:

Engagement with services and support:

Triggers, behaviours and orders:

Referral form minimum standards

<ul style="list-style-type: none"> • What are the client's criminal convictions and when were they convicted? • Is the client awaiting a trial or sentencing? • When is it expected and is a custodial sentence possible? • What were the circumstances surrounding their conviction(s)? 	<ul style="list-style-type: none"> • What has changed since they were last convicted? • Is the client engaged with services (i.e. Probation, DRR etc.)? • How well does the client engage with the support? • What on-going support will the client require? 	<ul style="list-style-type: none"> • Is offending behaviour linked to drug, alcohol or other support issues? • Is the client currently banned from any areas in London (e.g. ASBO or CBO)? • Will the client require approval from agencies before accommodation can be accepted (i.e. MAPPA or Jigsaw)?
--	--	---

Example:

Brian's most recent conviction has been for breach of his ASBO for entering the Shepherd's Bush area this was in July 2012 (ASBO to expire May 2014). Most of Brian's other convictions have been public order offences and being drunk and disorderly (which lead to his ASBO).

Brian is monitored by the Jigsaw Team and they visit him every six months at the hostel to assess his him. Brian has managed much better in complying with his ASBO since he started to better engage with alcohol services after moving to the hostel.

Brian is a registered sex offender and must register where he is living with the local Jigsaw Team. The Jigsaw Team will be required to approve Brian's accommodation as suitable for someone with his history of sex offences (see below).

Brian must remain on the sex offenders register for 7 years after being convicted of a sexual assault in Feb 2011 when he groped a woman outside Hammersmith tube station – Brian was sentenced to 12 months imprisonment.

In 1998 Brian was convicted of taking a child without authority and received a 12 month probation order. Brian's account of this was that he took his sister's child following an argument with her. Brian said he did not harm the child and cannot recall the exact details around this incident.

In 1996 Brian was convicted of burglary and received a 12 month probation sentence, we have not been able to source specific details around this offence. Brian has not been able to recall the details himself.

In 1990 Brian was convicted of arson for which he received a 6 month prison sentence. We have not been able to ascertain the details around this and Brian states that he does not recall the conviction. There have never been any further concerns around this issue since, and it is not determined to be a current risk.

Brian cannot be housed in the immediately locality of schools or currently within the Shepherd's Bush area of Hammersmith & Fulham.

Other Support Needs

Immigration status – due to the benefits system changes and Right to Rent laws brought in we have to ask about immigration status and gauge ongoing eligibility for benefits.

Details of past/present support needs – you can include anything in here, but if in 'Immigration status' you have selected EEA National or any type of Leave to Remain other than Indefinite please give details here.

- If your client has Limited Leave to Remain please tell us when it is due to run out and the likelihood of it being renewed.
- If your client is an EEA national please tell us about their history of work and/or claiming income benefits in this country – length of time, number and length of gaps,

periods of time out of the country. If they are on ESA it can be useful to know the reason for their ESA and whether or not this eligibility is likely to change (e.g. if they have serious physical health issues that aren't going to improve) and when they are currently signed off until.

- If you haven't provided it elsewhere you may also want to give details about family relationships and social networks if applicable e.g. does the client want and need to engage with support around rebuilding family relationships or contact?

6.4.7 Risk assessment

- If you answer 'yes' to any of the sections on the Risk Assessment, you must then provide detailed information relating to the risk(s).
- Include information based upon your own work with the client, as well as known history around these risk
- Include details of the circumstances around incidents, the actions taken to manage risk, including the dates that the incidents occurred.
- Please provide risk management strategies that have been put in place to manage and reduce these risks as well as describing their effectiveness.

This section of the form will likely contain information that crosses over from other sections; use this area to elaborate on the risks associated with physical and mental health, drug and alcohol use as well and behavioural issues and give details around recent incident(s). For all different risk areas please consider the following:

What risk does the client pose to themselves or others?	Engagement with treatment and services:	Triggers, behaviours and tenancy issues:
<ul style="list-style-type: none"> • Please give details of any incidents, particularly the most recent incident(s). • What was the context of the incident(s)? Were there any mitigating or contributing factors? • How frequently do incidents take place? 	<ul style="list-style-type: none"> • What services or support does the client currently receive in relation to this? • What on-going support will the client need to manage this issue? • What strategies does the client and staff have to minimise any risk? 	<ul style="list-style-type: none"> • How were the most recent incidents managed? • Are there triggers that lead to increased risk? • How do these issues impact on managing their tenancy?

Example 1:

Kathy has an eating disorder (anorexia) and has been engaged with services around this since the age of 22. Kathy engages monthly with her psychologist at the CMHT and attends counselling sessions every week. Kathy must ensure she maintains specialist support around her eating disorder and alcohol use. Kathy is prone to falls when she has been drinking, and due to her physical frailty has sustained serious injuries. Her last fall was approximately six months ago; she fell in the street while intoxicated. Swelling and bruising on her arm and face were so severe she required hospital treatment. The most serious incident occurred approximately 12 months ago; Kathy fell down the stairs in the hostel and broke her leg. Due to her frailty, she spent many weeks in hospital being treated and was later transferred to the eating disorder ward for three weeks before being discharged back to the hostel.

Example 2:

Ali's behaviour when intoxicated (alcohol) has frequently been an issue at the hostel. There are often (about once a month) incidents in which Ali confronts other hostel residents when drunk and has also become abusive to staff; when abusive he is asked to leave the hostel premises.

The most serious incident occurred 6 months ago following an argument with another resident; Ali tried to kick the resident's room door in. The police were called and Ali was arrested but later released without charge. Ali's confrontation with other residents often centres on the use of

communal facilities when Ali sees other residents leaving a mess behind or when he feels his property has been moved or damaged by another resident. In a self-contained property it is likely that such risk would be significantly reduced.

6.5 Client consent

- You must print off the Client Consent Form (link is found at the bottom of the main referral page). You and your client must read through the form ensuring that your client understands what it says both about the Clearing House offer and about them giving consent to share their information. If you have any questions relating to this, then please contact the Clearing House to discuss.
- If you and your client agree to and understand the consent statement please ask the client to sign the consent form and upload a scanned copy to the referral form. You must then also tick the Worker and Client Declaration boxes on the main page of the referral form.
- Submit the referral form to Clearing House!