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| **DOCUMENT TITLE:** | **Referral and Admissions.** |
| **CATEGORY:** | Operational. |
| **LAST REVISED:** | December 2022 |
| **VERSION:** | 1.1 |
| **DUE FOR REVISION:** | November 2024 |
| **OWNED BY:** | Darren Lang |
| **RELATED DOCUMENTS:** | Safeguarding procedure  Exiting a client procedure |

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| **OUR VISION:** | Through commitment, creativity and expertise, Acorn will inspire and motivates change within communities and future generations by enabling individuals to achieve a Life Worth Living |

**Overview**

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| **Key principles.** | A thorough assessment and risk assessment is completed which provides information about the service, assess motivation to access treatment and gather information about risk, to ensure any risks can be managed. |
| **Applicable to – Supported Housing.** | Acorn Recovery Projects offer supported housing in Manchester and Rochdale. Both services  Each property has single room occupancy with shared bathroom, kitchen, and lounge facilities. Rochdale has one en-suite downstairs which is suitable for anyone with walking difficulties.  The service is for 18 years and over, with no upper age limit. Access to the service is funded through housing benefit |
| Eligibility Criteria: | * Aged 18 or over, no upper age limit * Abstinent from drugs and/or Alcohol – you must have been deemed medically fit to enter our supported housing by a medical professional from an inpatient or community detox programme, or a care manager in the community. * All clients entering our supported housing project must be eligible for housing benefits. * A contingency plan for unplanned discharge is in place and has been agreed prior to admission e.g., move to alternative supported accommodation. If client has NFA status and the client continues to disengage with our service and all efforts have been made to source alternative accommodation, then the client will be asked to present as homeless * Motivated to access and engage in the support offered by Acorn or by one of our partner agencies * To be willing to comply with all terms and conditions within the houses, including drug/alcohol screening, adhering to curfew times and engaging in house chores. * That individuals can understand the process, the information they are being given and make informed decisions for themselves |
| Limitations to Access: | * We are unable to accommodate families or individuals under the age of 18. * We do not operate blanket exclusions. Decisions will be based on the information collected as part of the assessment process and any risk presented by them. * Any individual that has serious convictions for arson and our insurers deem too high risk * Any individual that has high risk mental health needs, that as a service we feel cannot manage * Any individual that has high risk sexual offences, and we feel unable to keep the individual safe * There is a right to appeal if an applicant is rejected for any reason and a copy of how to do this will be issued with any refusal decision.   Decisions are approved by the team leader with input from housing support staff. |
| Assessment process: | A thorough assessment and risk assessment is completed which provides information about the service, assess motivation to access treatment and gather information about risk, to ensure any risks can be managed.   * Referral received and assessment booked in within 7 working days * Assessment will take place in custody or wherever the client deems suitable in the community. Telephone assessments can be offered however we do prefer face to face. * A decision of the assessment will be given to the individual at the point of assessment. * A bed date cannot be guaranteed, we will work towards securing a bed for prison releases and if a bed is not available for community referrals, they will be put on the waiting list. * All CJ clients will be informed that we will be requesting RMP and overview of pre cons from probation. |
| Managing Prioritisation | We are committed to manage the need to access our services in the fairest and most equitable way. Prioritisation is based on assessment, physical health needs .  We shall assess and prioritise applications giving priority to people in greatest need of the Service.  Discharge process:  Planned Discharge Definition: This is a prior arranged exit from the service usually coinciding with the length of funding.  Unplanned Discharge Definition: An exit from the service that was not envisaged. Examples could be a relapse, threatening behaviour/violence.  There is a warning process whereby if a client moves through the stages, Stage 1, stage 2, the final stage is a 28-day notice, and then discharge.  Care manager will be kept informed if clients are issued with warnings.  A serious incident that results in immediate discharge.  If a decision is made to discharge an individual before their expected end date, staff will follow the client discharge plan, and we will inform the care manager and any other consented persons on file.  Managing a safe discharge, The services have a responsibility to ensure anyone leaving the service which is unplanned is kept as safe as practicably possible, This might involve:   * Not discharging out of hours (during the night/weekends when other services are closed) * Care manager has been kept informed of any warning processes and agree with the discharge plan * Always endeavour to source alternative accommodation * Referral back to community service * Consented concerned others are kept informed * If individuals leave without informing staff, concern for welfare is raised with appropriate services   Relapse doesn’t always result in immediate discharge, work will be done with individuals to understand the relapse, if a person wants to remain in treatment, and the care manager agrees, there may be the possibility to remain.  An individual who chooses to leave treatment, will not be discriminated against if attempting to reengaging in treatment later. |
| Reasons for discharge: | * Relapse – this is done on a case-by-case basis and does not always result in immediate discharge * Violence to other service users and/or staff * Escalation through warning process that results in the final warning and discharge * Not engaging in the therapeutic programme * A decline in physical health that cannot be managed by the service * A decline in mental health that cannot be managed by the service |
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