**Next Steps Accommodation programme (NSAP):**

**Mental health & Social/Wellbeing support**

**Next Steps Accommodation Programme (NSAP)**

The Next Steps Accommodation Programme (NSAP) is funded by the Ministry of Housing, Communities and Local Government (MHCLG) and makes available the financial resources to support local authorities and their partners to prevent rough sleepers accommodated during the pandemic from returning to the streets.

**Mental Health & Social/Wellbeing Support**

Many individuals who have experienced homelessness and rough sleeping have also experienced issues with their mental health and wellbeing.

Health for Homeless (H4H), Adult Social Care, Pentreath Ltd, Rethink Mental Illness and Cornwall Mind will work together to provide mental health and social wellbeing support to help individuals to develop the resilience, resources and skills they need to transition out of homelessness and remain in accommodation.

We will provide information, advice and guidance as well as support to achieve identified goals to include:

* Specialist assessment of mental health and social wellbeing
* Development of skills to self-manage mental health.
* Signpost to other statutory and third sector organisations for support not provided by the programme as identified on an individual basis.
* Reduce isolation and establish solutions for sustainable social inclusion.
* Support individuals to move towards training and employment.

**Eligibility**

* Current rough sleepers
* Those in temporary/emergency accommodation
* Those who have just moved into supported accommodation (less than 3 months)
* Those ready to move on from supported accommodation where mental health support could ease the transition

**Referrals**

Referrals to be made using the attached referral form to Cornwall Housing Limited on [Mentalhealth.Cornwall@cornwallhousing.org.uk](mailto:Mentalhealth.Cornwall@cornwallhousing.org.uk)

**Or by telephone:** Mobile: 07926 077655

**Referral Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | |
| **Name:** | |  | | **D.O.B.** | |  |
| **Contact Tel Number** | | **Date of referral** | | | | |
| **NHS Number (*if known*):** | |  | | | | |
| **Address** | |  | | **GP:** |  | |
| **Accommodation status**  (tick applicable) | | ☐ Rough sleeper  ☐ Sofa surfing  ☐ Crisis accommodation  ☐ Temporary accommodation  ☐ Supported accommodation (less than 3 months)  ☐ Supported accommodation ready for move on | | | | |
| **Referral Details** | | | | | | |
| **Please highlight your needs by ticking the relevant boxes (at least one box to be ticked to qualify):**     |  |  |  |  | | --- | --- | --- | --- | | ☐ Alcohol issues  ☐ Bereavement  ☐ Emotional distress  ☐ Childhood trauma  ☐ Communication needs | ☐ Debts / Financial problems  ☐ Positive activity  ☐ Domestic abuse  ☐ Drug issues | ☐ Education / Employment  ☐ Exploitation from others  ☐ Building a social network  ☐ Learning needs | ☐ Mental health  ☐ Suicidal thoughts  ☐ Self-harm behaviours  ☐ Social stressors | | | | | | | |
| **Please provide additional specific details of how we can help you?** | | | | | | |
| **Drug and alcohol use:**  **Drugs**  Current Drug use……………………………………………………………………………………  Amount ………………………………………………………………………………………………….  Route……………………………………………………………………………………………………  **Alcohol**  Current alcohol use……………………………………………………………………………………  Amount ………………………………………………………………………………………………….  How Often ……………………………………………………………………………………………..  Is the client currently open to We Are With You (WAWY)? YES/NO | | | | | | |
| **Current Service Involvement: (**anyone else working with the client) | | | | | | |
| **Current and historical risk to self or others:** | | | | | | |
| **The client consented to referral:** YES / NO | | | | | | |
| **I, …………………………agree for my information on this form and health care records (CFT) to be shared with the multi-agency team (CFT, Adult Social Care, Pentreath, Rethink and Cornwall Mind). The purpose of sharing your information is to ensure that the service offered is safe and effective whilst meeting your needs. Records will be kept securely on relevant recording systems.**  **Signature…………………………………………………… Date …………………………………** | | | | | | |
| **Referrers Name (if agency referral):** |  | | | | | |
| **Referrer’s Job Title/Email:** | | |  | | | |

**Please email the completed form to:** [Mentalhealth.Cornwall@cornwallhousing.org.uk](mailto:Mentalhealth.Cornwall@cornwallhousing.org.uk)

**Or make a referral by telephone by contacting CHL:** Mobile: 07926 077655