**Date of Request** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health Support Teams (MHST’s) provide evidence based interventions to support children and young people with mild to moderate emotional health needs. The service can accept referrals for children and young people **aged** **5-18** who attend designated schools in **Furness, Morecambe, Heysham** and **school years 4 to 11** who attend designated schools in the **Carlisle** locality.

Please complete this form with the child/young person and where appropriate with the parent/carer and provide as much detail as possible

If any support is needed in completing the form or if you would like to discuss your request for support then please contact the MHST email inboxes, either: [CarlisleMHST@barnardos.org.uk](mailto:CarlisleMHST@barnardos.org.uk) or [furnessmhst@barnardos.org.uk](mailto:furnessmhst@barnardos.org.uk) or [morecambemhst@barnardos.org.uk](mailto:morecambemhst@barnardos.org.uk)

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| **Privacy Notice** |
| In order to provide a service that is in the public interest we are required to hold information about the child and family. As good practice we will assess the child’s capacity and gain informed consent to access the service and share information where this is required. If you use our service Barnardo’s will ask for some details about you. We will record your details, why we are helping you and the work that we are doing. We will keep the information you give us safe. Only Barnardo’s staff will use the information you give us. But sometimes we may need to share some of your information. |

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| **Child / Young Person wanting support** | | | | | | |
| **Name of Child / Young Person** |  | **NHS number** | |  | | |
| **Full address of Young Person** |  | | | | | |
| **Contact number/email for CYP (where appropriate)** | Email  Mobile number  Permission to contact above Yes  No | | | | | |
| **Ethnic Origin** |  | **Date of Birth** | |  | **Gender** | Female |
| **Name and Address of GP Practice** |  | | | | | |
| **Interpreter required?** | Yes  No  Details: | | | | | |
| **SEND / EHCP needs** | Yes  No  Details: | | | | | |
| **Developmental needs** | ASC  ADHD  Other: | | | | | |
| **Is this child/young person open to:** | CAMHS  Other Mental Health Support  Details: | | | | | |
| **Social Care** | Looked After Child  Child In Need  Child Protection Plan  CAF/Early Help ID number: | | | | | |
| **NEET needs**  **(not on roll in education, employment or training)** | Yes  At risk | | | | | |
| **LGBT identity** | Yes  No  Details: | | | | | |
| **Does the child or young person give consent to the request for support?** | Yes  No  Details: | | | | | |
| **Does the parent/carer give consent to the request for support?** | Yes  No  Details: | | | | | |
| **Parent-Carer Contact Details** | | | | | | |
| Details of person(s) with Parental Responsibility (Names and Address).  Please include all person(s) regardless of whether they live in the same household. | | | | | | |
| Person 1 | | | Person 2 | | | |
| Address | | | Address | | | |
| Telephone No:  Email Address:  Can we leave a voicemail? ☐ Yes ☐ No  Can we text this person? ☐ Yes ☐ No  Can we email this person? ☐ Yes ☐ No | | | Telephone No:  Email Address:  Can we leave a voicemail? ☐ Yes ☐ No  Can we text this person? ☐ Yes ☐ No  Can we email this person? ☐ Yes ☐ No | | | |

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| **School Details** | |
| **Education Setting:** |  |
| **Name of Referrer:** |  |
| **Referrer contact details:** | Email:  Phone: |

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| **Risk Care** | | | | |
| **Risk Factors Present** | Yes Current | Yes Historic | None | If yes please detail (where, when, how, frequency) |
| Self-Harm |  |  |  |  |
| Suicidal Thoughts/Planning/  Behaviours |  |  |  |  |
| Parents/Siblings with Mental Health Difficulties |  |  |  |  |
| Safeguarding / Exploitation |  |  |  |  |
| Substance Use |  |  |  |  |
| Offending behaviour/activity |  |  |  |  |

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| Please let us know why you are making this referral: | |
| *In order to ensure effective and timely processing of this referral please complete ALL sections*. | |
| Please indicate if the child/young person is experiencing any of the following difficulties: | |
| Low Mood  Worry  Anxiety/avoidance  Insomnia  Negative Thinking  Problem Solving  Irritability  Low Confidence/Assertiveness  Interpersonal Challenges  Mild Phobias/Obsessive Compulsive Behaviours  Significant Life Events  Rigid/Ritualistic Needs i.e. Autistic Spectrum Condition (ASC) | |
| What impact are the difficulties having for the child/young person in the following areas: | |
| Education | None of the time  Some of the time  All of the time  Details |
| Family | None of the time  Some of the time  All of the time  Details |
| Friends/ Peers | None of the time  Some of the time  All of the time  Details |
| Self-Care | None of the time  Some of the time  All of the time  Details |
| What does the child/young person want to achieve with the support of our service? | |
|  | |
| Is there anything else you think is important for us to know? | |
|  | |
| Parent/carer – please sign to give consent to referral, sharing of information and agreement to access the MHST service:  Name: Signature: | |
| Young person - please sign to give consent to referral, sharing of information and agreement to access the MHST service:  Name: Signature: | |

Please return the completed form to the appropriate email address below, all referrals must be encrypted or password protected.

Barrow/Furness: [furnessmhst@barnardos.org.uk](mailto:furnessmhst@barnardos.org.uk)

Morecambe/Heysham: [morecambemhst@barnardos.org.uk](mailto:morecambemhst@barnardos.org.uk)

Carlisle: [CarlisleMHST@barnardos.org.uk](mailto:CarlisleMHST@barnardos.org.uk)

Last updated 11/02/2021

**Service Offer**

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| **MHST’s Can Do** | | |
| **Low Mood** |  | **Irritability/Anger** |
|  | **General** **Anxiety** |  |
| **Panic Management** |  | **Mild Obsessive-**  **Compulsive Difficulties** |
|  | **Social Anxiety** |  |
| **Emotional Regulation** |  | **Negative Thinking** |
|  | **Health Anxiety** |  |
| **Superficial Self Harm** |  | **Relationships** |
|  | **Separation Anxiety** |  |
| **Sleep Support** |  | **Worry Management** |
|  | **Simple Phobias/Avoidance** |  |
| **Problem Solving** |  | **Resiliency Support** |
|  | **Rigid Behaviours** |  |
| **Low Confidence** |  | **Interpersonal Challenges** |
|  | **Mindfulness** |  |
| **Individual Support** |  | **Group Support** |

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| **MHST’s Can Support With** | | |
| **Parenting** |  | **PSHE** |
|  | **Emotional Health Training** |  |
| **Whole Education Care** |  | **Learning Culture** |
|  | **Transition** |  |
| **SEND** |  | **Autism/ADHD** |
|  | **Children Looked After** |  |
| **Education Reluctance** |  | **Behaviour** |

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| **Refer to Specialist Services** | | |
| **Depression** |  | **Extensive Anxiety** |
|  | **Eating Disorders** |  |
| **Complex Emotional Regulation** |  | **Suicidal Ideation/Planning** |
|  | **Extensive Phobias** |  |
| **Trauma** |  | **PTSD** |
|  | **Extensive Obsessive-Compulsive Difficulties** |  |
| **Complex Attachment** |  | **Psychosis Symptoms** |
|  | **Sexualised Behaviours** |  |
| **Pain Management** | **Substance Use** | **Emotional Crisis Care** |

**Child or Young Person with mild to moderate emotional health difficulties identified by self and/or education setting, parent/carer, or other professional.**

- A mild emotional health need is when a person has a small number of difficulties that have an effect on their daily life.

- A moderate emotional health need is when a person has more difficulties that can make their daily life much harder than usual.

(NICE Guidelines (2011))

Parent/carer

Other professional

Child or Young Person

Education Setting

Conversation takes place with the child or young person about their emotional wellbeing. The role of the MHST is introduced and support for emotional health is discussed.

Is the child aged 16 and above?

*Secondary*

Is the Young Person in Y7 and above?

*Primary*

Is the child in Year 6 and below?

Young Person to be encouraged to involve parent/carer wherever possible.

Presumed to have capacity unless deemed otherwise

Young Person to be encouraged to involve parent/carer wherever possible.

Referrer to assess if YP competent to consent to request for support and/or information sharing with MHST

Referrer to discuss with person with parental responsibility to gain consent for MHST request for support/information sharing

If consent given, complete request for support form and send to MHST area inbox.

MHST staff can help with this

If consent given, request consultation either via named MHST practitioner or MHST area inbox

**Or**

Consultation arranged with MHST

Request for support screened by MHST

The practitioner may contact the person making the request, child or young person and parent/ carer where appropriate

Alternative recommendations

Request received and accepted

Request outcome fed back to child or young person, parent/carer (where appropriate) and person making request for support

Assessment

Signpost and closure

Accepted for intervention

Whole school approach

Working with the CYP Team

Senior Prac/ CBT

Group work

EMHP

Consultation

Review

Consultation

Whole school approach

Whole school approach

Step across within MHST

Refer onwards

Intervention complete



Refer onwards

Intervention complete

Closure

Refer onwards

Refer onwards