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| **Privacy Notice Statement & CONSENT** |
| **Please note by completing this referral, Compass will expect the following (please tick to confirm):** 1. This referral has been discussed and agreed by the parent/carer (if under 16 years) and young person [ ]
2. You consider the young person to have capacity to give informed consent [ ]
3. You have explained that any information held on this form will be stored by Compass on a secure database [ ]

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| **Has the young person consented to this request for support?** Yes [ ]  No [ ]  |
| **Has the child’s parent/carer (if under 16) consented to this request for support?** Yes [ ]  No [ ]  |
| **Does the child/young person consent to us contacting their parent/carer?** Yes [ ]  No [ ]  |
| **Does the parent/carer (if under 16) or young person, consent to Compass contacting other agencies to discuss the referral if required?** Yes [ ]  No [ ]   |

 **PLEASE NOTE: If the boxes above have not been completed, you will need to confirm these before a referral will be processed.**Signed by referrer:…………………… Signed by parent/carer:………………..……Signed by young person:…………..……. |
| Barnsley Mental Health Support Team works with children, young people, families, and schools to provide low intensity one-to-one interventions (max 8-10 sessions) to children and young people aged 5-19 with mild to moderate emotional health and wellbeing needs and CYP who experience higher levels of distress following a bereavement.In order to make a referral to the Mental Health Support Team please note the following inclusion and exclusion criteria. The MHST **can** support children and young people with (please tick those that apply):  [ ]  Low mood: sadness, low motivation  [ ]  Mild to moderate anxiety: worries, irrational fears, and concerns  [ ]  Common challenging behaviours; angry outbursts, pushing boundaries, frustration, and distress. [ ]  Family and peer relationship difficulties  [ ]  Difficulty adjusting to change and transition.  [ ]  Difficulty managing emotions. [ ]  Bereavement. The MHST **cannot** work with children and young people who: * Are currently engaging with any other emotional-wellbeing service (within the School or externally).
* Have a clinical diagnosis of ‘clinical’ depression, severe anxiety, Obsessive-Compulsive Disorder (OCD), schizophrenia, eating disorders, psychosis.
* Have self-harmed long term and currently experiencing suicidal thoughts/behaviours.
* Have a moderate – severe learning disability.
* Are requiring long-term therapy.
* Are in crisis or requiring out of hours support.

**PLEASE NOTE**: If you are unsure whether a child or young person would benefit from support from MHST please call our duty team on **01904 666371** (Monday – Thursday 9am to 5pm / Friday 9am to 4.30pm).  |
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| **CONTACT DETAILS OF REFERRER** |
| **Name:**  | **Relationship to child/young person:**  |
| **Organisation (if applicable):** |
| **Address:**  |
| **Referrer’s contact phone number:**  |
| **Referrer’s email address:**  |
| **Have you spoken with a MHST link worker or duty worker?** Yes [ ]  Who?......... No [ ]   |
| **How did you hear about the MHST?** |

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| **CONTACT DETAILS OF CHILD OR YOUNG PERSON** |
| **Child/young person’s full name:**  | **Preferred name/pronoun:** |
| **Child/young person’s address:**  |
|  | **Postcode:** |
| **Child/young person’s mobile phone number/landline number:**  |
| **Child/young person’s date of birth:** | **Age:** |
| **Child/young person’s gender:**  | **Religion:** |
| **Ethnicity:** White British [ ]  White other [ ]  Mixed [ ]  Asian or Asian British [ ]  Black or Black British [ ]  Other Ethnic Groups [ ]  Not known [ ]  Other [ ]  **If other, please specify: ……………….** | **Main Language:****Is an interpreter required?** Yes / No**Documents required in main language?** Yes/No |
| **Next of Kin:**  |
| **Accommodation status:** (i.e. living with parents, living with relatives, fostered, adopted, independent living) |
| **Are there any methods by which the child/young person does NOT want to be contacted?** (Unless stated otherwise we will call, text, email and send letters when relevant) |

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| **CONTACT DETAILS OF PARENT/CARER** |
| **Parent/Carers name:** | **Relationship:** |
| **Parent/carers address:** |
| **Parent/carers phone number:** |
| **Parent/carers email address:** |
| **Main Language of Parent/carer:** | **Is an interpreter required?** |
| **Are there any methods by which the parent/carer does NOT want to be contacted?** (Unless stated otherwise we will call, text, email and send letters when relevant)  |

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| **SCHOOL/COLLEGE DETAILS (if applicable)** |
| **Name of the school the young person attends:**  |
| **Year group:**  |
| **Name of key contact / member of staff at school:**  |
| **Telephone number of the school:**  |

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| **GP DETAILS** |
| **GP Name:** |
| **Name and Address of G.P Surgery:** |
| **Phone Number:** |
| **Email address:** |

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| **DOES THIS YOUNG PERSON HAVE ANY ADDITIONAL NEEDS** |
| Child protection plan/ child in need plan/ early help **(if yes, which one…)** | Yes [ ]  No [ ]  Don’t know [ ]  |
| Elected Home Educated  | Yes [ ]  No [ ]  Don’t know [ ]  |
| LAC/Care Leaver  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Young Carer  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Excluded / at risk of  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Substance Misuse  | Yes [ ]  No [ ]  Don’t know [ ]  |
| NEET | Yes [ ]  No [ ]  Don’t know [ ]  |
| Special Educational Need or Disability (SEND)  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Physical health needs (including allergies)  | Yes [ ]  No [ ]  Don’t know [ ]  |
| Education Health and Care Plan (EHCP)  | Yes [ ]  No [ ]  Don’t know [ ]  |
| **If any of the above are YES, please provide more details:**  |

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| **Please give a brief summary of the difficulties the child/young person is experiencing:** (What is the reason for referral? What is the impact of this? What has been tried before?) |
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| **WHAT IS THE VIEW OF THE YOUNG PERSON AND PARENT/CARER** (What would the child like to achieve from support, what would the parent carer like to see the child achieve) |
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| **ARE YOu AWARE OF ANY CURRENT OR PREVIOUS RISKS WITH THE CHILD/YOUNG PERSON/FAMILY?**(Please include risk to self, others and/or safeguarding concerns, appropriate for home visits. Please attach any current or previous risk assessment if applicable) |
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| **Please list any other agencies involved in supporting the child/young person**(Please list contact names/numbers if known) |
| Does the parent/carer (if under 16) or young person consent to Compass contacting the agencies above to discuss the referral if required? Yes [ ]  No [ ]   |

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| COMPASS MHST OFFICE USE ONLY |
| Date referral received | Received via which channel | Duty Worker |
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| ONCE COMPLETE PLEASE SEND THE COMPLETED FORM TO:

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| **Email (MUST BE SECURE):** | **Postal address:** |
| **Secure\* email address:** **info**.**barnsleymhst@Compass-uk.org**\*NB In order for this to remain secure you must use an EGRESS email address to send the referral  | Compass Barnsley MHST 1 Blucher St, Barnsley S70 1AP |
| **Secure\* email address:** **compass.barnsleymhst@nhs.net**\*NB In order for this to remain secure you must use an NHS email address to send the referral  |
| *If you are unable to send the referral securely please send via post or contact Compass MHST duty line on the number below.* |
| **Telephone number – 01904 666371** |

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| Following receipt of your request for service.1. Compass MHST allocation meetings are held weekly.
2. Once the request has been to allocation one of the team will be in touch with the referrer regarding the outcome and next steps (if applicable)
3. If Compass MHST accepts the request the child/young person will be allocated a Compass MHST practitioner who will then carry out an assessment to assess the most appropriate intervention/s
4. Interventions are a maximum of 8 – 10 sessions.
5. Progress is reviewed at each session.
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**If you have any questions you can call the duty line on 01904 666371.Monday – Thursday 9am to 5pm, Friday 9am to 4.30pm** |