**Mental Health Support Team:**

Information and guidance about making a request for support

**After considering this guidance, if you remain unclear about the suitability of a child or young person for MHST please call us on 01392 386825 or email** **cfhd.mhstadmin@nhs.net** **to speak to a member of the team.**

Please note, the following abbreviations are used within this document:

MHST – Mental Health Support Team

EMHP – Education Mental Health Practitioner

LI-CBT – Low Intensity Cognitive Behavioural Therapy

**Overview of our interventions and aims:**

A typical intervention from MHST will typically involve:

1. A comprehensive initial assessment with a supervisor (which we call a wellbeing conversation) to asses suitability for MHST.
2. An appointment with an EMHP to explore the situation in more detail and establish which of our LI-CBT interventions is most appropriate.
3. Six to eight sessions of the agreed LI-CBT intervention.

It is possible many of the young people we see could improve during this time. However, some children and young people may require fewer contacts or the support may span a longer period of time. As a result, EMHP’s would then refer on through a stepped care approach or signpost as appropriate.

Initial sessions will involve psycho-education, leading to structured sessions using LI-CBT informed discussions to develop understanding of the reported difficulties. The EMHP will seek to utilise parental/carer support to create SMART goals for therapy and work towards sustainable change.

All interventions will be focused on supporting CYP and their parents to use and engage with the materials, including helping them to problem solve any difficulties faced and provide the motivation and encouragement to work through the materials. This can have a very typical talking therapy (cognitive) approach or be utilising behavioural approaches using exposure techniques and working through behavioural experiments.

On the following pages you will find tables in order to help make the criteria both distinctive and clear. The tables summarise the specific conditions the intervention could be expected to address, as well as those they ***should not.*** They also identify those situations where discretion is required and a case by case decision will be made.

**Inclusion criteria**

**Age:**

Referrals are welcome for all children between the ages of 5 and 18.

**Location:**

Referrals are welcome from children enrolled at the following schools only:

INSERT

If you would like to discuss…

**Diagnosis:**

Requests are considered on a needs basis and no diagnosis is required. MHST will offer a service to all CYP who attend partner schools that are suitable for the interventions MHST offer. Specific detail around suitable presentations and complexity are listed on pages 3 & 4.

**Complexity:**

We work in partnership with children and young people experiencing mild to moderate mental health difficulties (anxiety, low mood and behavioural difficulties). The team are unable to work with serious and enduring mental health difficulties including complex, or moderate to high need situations or presentations.

We are commissioned to provide a clear and tailored low-intensity intervention and will therefore not be appropriate for children and young people requiring a complex multi-agency approach.

**Expectations from those already offering support:**

Please consider the desire the child or young person has to engage. Our interventions require commitment and a participatory approach. LI-CBT is solution-focused and problem-solving in its delivery. A discussion with the child, young person or their parents (younger children) before making a request about the importance of this participatory and goal focused approach is vital.

Young people and their families will also need to understand that engagement in LI-CBT will require a commitment to working at home and completing ‘*home-work’* type tasks in order to facilitate the delivery of the intervention. Most interventions will require commitment outside of the sessions themselves.

**Risk**

**INSERT**

**Table 1 – Conditions:**

|  |  |  |
| --- | --- | --- |
| Yes | Maybe | No |
| Common mental healthdifficulties that may respondto early intervention / lowintensity approaches | Common mental healthdifficulties that may respond to early intervention / low intensity approaches, however consideration required concerning the severity and impact of the presenting difficulties to determine suitability | Significant levels of need/complex conditions which are not suitable for brief early intervention / low intensity approaches |
| Low Mood / Mild toModerately SevereDepression• Panic Disorder• Panic Disorder &Agoraphobia• Generalised AnxietyDisorder / Worry• Simple Phobia (but notblood, needle, vomit)• Sleep problems• Stress management• Behavioural Difficulties | Anger difficulties• Low self-esteem• Mild social anxiety disorder• Some compulsivebehaviours• Mild health anxiety• Assertiveness/interpersonalchallenges (e.g., with peers)• Self-harm is disclosed but isassessed as linked to low moodbut is not assessed as enduring and high risk innature• OCD | • Pain management• PTSD• Bipolar Disorder• Psychosis• Personality Disorders• Eating Disorders• Chronic depression/anxiety• Established health anxiety• Historical or currentexperiences of abuse or violence• Complex interpersonalchallenges• Bereavement• Active, enduring andsignificant self-harm• Relationship problems |

**Table 2: The CWP-CYP role**

|  |  |
| --- | --- |
| WPCYPs should: | WPCYPs should not: |
| Assess and support people with mild to moderate mental health problems (anxiety, low mood and behavioural difficulties). | Routinely assess and triage children andyoung people with severe, complex orenduring mental health problems, or those presenting with complex issues. |
| Offer low intensity, focused, evidence based interventions outlined in the CWP-CYP curriculum and certificate training programme:• Behavioural activation• Behavioural experiments• Cognitive restructuring• Exposure and habituation / Exposure andresponse prevention• Worry management strategies• Social Learning theory based parentsupport and parent lead CBT• Behavioural and emotional regulationstrategies (sleeping, toileting, feedingetc.)• Computer based CBT• Lifestyle management• Relaxation• Problem solvingIntervention Diagram on final page | Be involved in complex, or moderate to high need situations or presentations.Hold cases referred to CAMHS or co work high need cases. |
| Signpost people and facilitate access to other services when appropriate. | Support children and young people with high levels of risk or needing a specialist level of care or intervention. |
| Work through a variety of media such astelephone, internet and face-to-face and in a range of settings close to where families live – such as schools, health centres, community or Youth venues or children’s centres. | Work in isolation or in ‘clinic’ style settings. |
| Review children and young peoples’ progress and record outcomes achieved and adhere to and collect the WPCYP minimum data set requirements for a minimum of 90% of cases. | Close cases until all recording including monitoring of outcomes is completed. |
| Be able to access specialist input quickly where complexity, risk or safeguarding factors emerge.Receive weekly WPCYP case management supervision and fortnightly clinical skills supervision. | Operate without appropriate supervision /access to specialist support when needed. |

**The Interventions and the Symptoms they hope to improve:**

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