**Referral into the Single Point of Contact (SPOC) for Emotional Wellbeing and Mental Health services**

This service is for children, young people under 18 and their families who have a GP in Croydon. We cover the following conditions:

Anxiety, depression, stress, eating disorders, psychosis, suicidal behaviour, ADHD, autism spectrum disorder, emotional and behavioural difficulties.

**Before you start….the importance of gaining consent**

A referral into the SPOC must always be discussed with the child and their family and consent for the referral should always be sought from those with parental responsibility unless to do so would place the child at further risk of harm. This means you have advised parents that they agree to their information being shared with partner agencies as per our [privacy notice](https://www.croydon.gov.uk/democracy/data-protection-freedom-information/privacy-notices/corporate-privacy-notice), so that the best offer of support can be sought. As with all requests for support into the SPOC, a brief record of the contact will be recorded on Croydon’s Child & Families Case Recording system. This recording does not mean the child will have a Children’s Social Care Record. Referrals may be forwarded, if appropriate, to partner services in the non-statutory sector, to Croydon Early Help and/or to other agencies who are best placed to meet the child or young person’s needs. If the decision is that the child or family could benefit from additional support or if there are safeguarding concerns, this will be discussed with the referrer first.

If you are worried about a **safeguarding** issue for a child and you are unable to contact the parents, this should not stop you from making a referral and you can discuss your concerns in the first instance with your organisation’s designated safeguarding lead and if needed the CSC Front Door Single Point of Contact (SPOC) on 020 8255 2888 for a consultation with a Social Worker.

In a mental health emergency the young person or family should try to arrange an urgent GP appointment or seek advice from NHS 111. In cases such as immediate or high risk of suicide or significant self-harm requiring urgent medical intervention a young person should attend A&E for a CAMHS crisis assessment.

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| **How to refer**  | Completed EWMH referrals should be sent to: Childreferrals@croydon.gov.uk |
| **Who to contact with a query** | For new cases: Childreferrals@croydon.gov.uk |
|  | If you have a query about a case that has already been accepted to one of the emotional wellbeing and mental health services, please contact that service:**SLAM CAMHS**: 0203 228 0000**CWP Programme:** 0203 228 0000**Off the Record**: 020 8251 0251**Croydon Drop In**: 020 8680 0404 |

All fields marked with an \* must be completed

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| 1. **Emotional Wellbeing and Mental Health Service Consent Box \***
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| Please ensure that all young people are aware of their referral as appropriate to their age and development stage. Parental consent is required for all young people aged 15 years and below other than in exceptional circumstances. Young people aged 16 or 17 must provide their own consent, any young person consenting to a referral without their parents knowledge must be assessed as Fraser competent.  |
| Is parent/carer aware of this referral? (child aged 15 and below) Y/N\* |  |
| If the referral is for young person over 16, are they aware their information may be shared with other agencies to identify the best service to meet their needs? Y/N\* |  |
| Have you gained consent? Y/N\* |  |
| If parents have not given consent please state why below |
|  |

1. **Child’s GP/Referrer’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name\*** | **Job title\*** | **Relationship to the child** | **Organisation** |
|  |  |  |  |
| **Email\*** | **Contact Tel No\*** | **Address including postcode\*** |
|  |  |  |

1. **Child/Young Person’s details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family name/Surname\*** | **Forenames\*** | **Date of Birth or EDD\*** |  **NHS Number**  |
|  |  |  |  |
| **Gender\*** | **Religion** | **Any special needs/disabilities? – are they a young carer?** |
| **Female** |  |  |
| **Ethnicity\*** | **Child’s first language\*** | **Interpreter required?** |
|  |  |  |
| **Does the child have an Education, Health and Care Plan (EHCP)?** |
|  |
| **Current address\*** |
|  |
| **Any other significant information e.g. a secondary address or telephone number** |
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| 1. **Risk Management**
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| Are any of the following an issue for the young person?Please provide us with specific details to all us to assess current risks to the child/young person.  |
| Self-harm requiring minimal interventioneg. Type of self-harm, frequency, date of last incident, number of total incidents |  |
| Self-harm requiring medical interventioneg. Type of self-harm, frequency, date of last incident, number of total incidents |  no |
| Suicide Attempts  | no |
| Suicidal Ideation | no |
| Risk to others | no |
| Symptoms of PsychosisEg. hallucinations, delusions, paranoia, unusual though for behaviour, deterioration in usual functioning | no |
| Eating disorder Please ensure height and weight are recorded | no  |
| Drug/Alcohol Misuse  | no |
| Youth Offending issues  |  no |

**5. Parent/carer’s details**

|  |  |  |
| --- | --- | --- |
| **1. Family name/Surname\*** | **Forenames\*** | **Date of Birth or EDD** |
|  |  |  |
| **Relationship to the child\*** | **Does this person have parental responsibility?\*** | **Any special needs/disabilities?** |
|  |  |  |
| **Ethnicity\*** | **Parent/carer’s first language\*** | **Interpreter required?** |
|  |  |  |
| **Current address\*** | **Contact details - Tel. No & email\*** |
|  |  |
| **2. Family name/Surname** | **Forenames** | **Date of Birth or EDD** |
|  |  |  |
| **Relationship to the child** | **Does this person have parental responsibility?** | **Any special needs/disabilities?** |
|  |  |  |
| **Ethnicity** | **Parent/carer’s first language** | **Interpreter required?** |
|  |  |  |
| **Current address** | **Contact details - Tel. No & email** |
|  |  |

1. **Other household members and significant relationships**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name/s** | **DOB/EDD** | **Relationship** | **Ethnicity** | **Language** | **Address and Contact details** |
|  |  |  |  |  |  |
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1. **Educational setting (nursery/school/college)**

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| --- | --- |
| **Name of Nursery/School or College\*** |  |
| **Address****Tel No** |  |
| **Manager/Head Teacher** | **Contact details** | **Nursery/ class/ form teacher** | **Contact details** |
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| 1. **Reason for Referral. What are you and/or the child and family worried about?\***

*Please provide as much information as possible in this box, for example:**What the impact is on the child young person?**What is working well and what has already been tried? (attach any multi-disciplinary assessment reports, where appropriate).**What do you want to happen next?* |
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| 1. **Has the child/ young person experienced any mental health difficulties in the past?\***

If yes, please detail issues and action taken |
| **no** |

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| 1. **If you would like to provide further information please include below**
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1. **Any other professionals/agencies involved with the child and family, if known**

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| --- | --- | --- | --- |
| **Name of professional** | **Role** | **Agency name** | **Contact details** |
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