Assessment and Care of Children and Young People with Mental Health Needs, who are placed in an Acute General Hospital Ward Policy
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1. INTRODUCTION

Children and Young People with acute mental health needs may need admission to hospital for assessment and treatment. Acute general hospital wards (typically a paediatric ward) are often the first location for admission. Clinical staff from Children and Adolescent Mental Health Services (CAMHS) have a pivotal role in working with the acute general hospital ward multi-disciplinary team (MDT) to assess, plan and co-ordinate care for these children and young people.

Out of Hours for those aged 16 and 17 years the adult crisis team may be involved in the assessment.

2. PURPOSE

The purpose of this policy is to clearly set out best practice guidance and CAMHS requirements for the assessment and care of children and young people who are admitted to an acute general hospital ward with mental health needs.

When any child/young person has been admitted to an acute general hospital ward with associated emotional and mental health issues, be that planned or unplanned; they, their parent / carer or legal guardian and the admitting ward staff should have clarity regarding the roles and responsibilities of CAMHS and the nature and frequency of contact that can be expected.

This policy aims to support staff to:

- Maintain the safety and well-being of the child/young person through a timely assessment, risk assessment and care and crisis plan
- Provide on-going assessment, care and support to the child/young person/family and the acute hospital ward during prolonged admission
- Provide a consistent approach and have clarity regarding their roles and responsibilities for the care of children and young people admitted to an acute general hospital ward with mental health needs.

2.1 Definitions/Explanation of Terms Used

FACE Risk Assessment: 'FACE' is an abbreviation of the name of the company that produce several toolkits to assess risk and needs in health and social care.

BMI: Body Mass Index

SOP: Standard Operating Procedure

3. SCOPE

This Policy applies to those patients/service users who have not yet reached their 18th birthday and are therefore defined as children and young people and covers:

- Those children and young people who have been referred to Trust services but whose needs and level of risk have yet to be assessed.
Those Children and young people who have been accepted by CAMHS and whose level of risk has been assessed and or has changed

This policy applies to all clinical staff in CAMHS, who as part of their work will assess children and young people (as defined in the scope) who have been admitted to an acute general hospital ward with associated mental health concerns.

Whilst it is recognised that this Policy will predominantly apply to CAMHS, staff from adult services may also be involved in the assessment of children and young people and therefore should be aware of the content.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

CAMHS staff should ensure they maintain their professional knowledge and competence by accessing available training and seeking advice and guidance through clinical and managerial supervision and using the resources available on the Trust intranet.

4.1 Care group Directors

Care Group Directors are responsible for:

- The implementation of the policy across the specified Care groups
- The on-going review of the policy to keep it up to date with current best practice
- Promoting collaborative working between services, in order that the needs of the patient remain at the centre of the process
- Providing reports to the Operational Management Meeting (OMM) on any issues associated with the implementation of the policy
- Facilitating effective joint working with internal and external partners and stakeholders
- Monitoring staff compliance with the Policy and Mandatory and Statutory Training Needs
- The development, implementation and monitoring of effective systems of supervision for clinical staff within their Care Group Service

4.2 Team Managers

Team Managers are responsible for:

- Making their staff aware of the contents of this policy.
- Monitoring the compliance of their staff with the contents of this policy.
- Facilitating Multi-disciplinary Team (MDT) discussion to assist decision making and communication of concern/ actions.
- Reporting any breaches in relation to this policy.
4.3 Paediatric Liaison Nurse

Paediatric Liaison Nurse is responsible for:

- Supporting staff with the implementation of this policy
- Reporting any breaches in relation to this policy.
- Escalating any clinical issues that impact on the delivery of this policy
- Facilitating Multi-disciplinary Team (MDT) discussion and / or individual supervision to assist decision making and communication of concern/ actions.
- Liaising with general hospital colleagues in relation to this policy

4.4 All Clinical Staff

Clinical staff are responsible for:

- Following the appropriate steps in this policy and informing the team Manager/ Paediatric Liaison Nurse where necessary of any issues that impact on the delivery of care as defined within this policy
- Reporting any breaches in relation to this policy.

5. PROCEDURE/IMPLEMENTATION

5.1 Best Practice Guidance Self Harm

There is a national recommendation that children up to 16 years of age who have self-harmed should have overnight observation on a paediatric ward and be assessed by CAMHS on the ward either on the same day or the following day dependent on the timing of the admission.

In accordance with national guidance for self-harm under ‘Special issues for children and young people (under 16 years)’ a paediatrician should normally have overall responsibility for the treatment and care of children who are admitted and have self-harmed. The admitting team should obtain the consent of someone with parental responsibility to undertake the mental health assessment of the child or young person.

5.1.1 Young people aged 16 and 17 years are not identified separately in national guidance and therefore referral, treatment and discharge following self-harm should be based on the overall assessment of needs and risk.

National Guidance states

- that the decision to discharge a person without follow-up following an act of self-harm should be based upon the combined assessment of needs and risk. The assessment should be written in the case notes and passed onto their GP and to any relevant mental health services.
- that a decision to discharge a person without follow-up following an act of
self-harm should not be based solely upon the presence of low risk of repetition of self-harm or attempted suicide and the absence of a mental illness, because many such people may have a range of other social and personal problems that may later increase risk. These problems may be amenable to therapeutic and/or social interventions.

- that temporary admission, which may need to be overnight, should be considered following an act of self-harm, especially for people who are very distressed, for people in whom psychosocial assessment proves too difficult as a result of drug and/or alcohol intoxication, and for people who may be returning to an unsafe or potentially harmful environment. Reassessment should be undertaken the following day or at the earliest opportunity thereafter.

See NICE guidance NG16: Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. Sections: 1.9.1.3. and 1.9.1.5 and 1.9.1.6 for under 16 years and 1.8.1.3, 1.8.1.4 and 1.8.1.5.

5.2 Response by local CAMHS services within working hours

Normal working hours are defined as Monday to Friday 09.00 to 17:00 hours

Out of hours are defined as after 17.00 hours and weekends/public bank holidays

5.2.1 CAMHS response to referrals made by admitting to wards in acute hospital settings

All children and young people placed on a paediatric / acute general hospital ward who require a mental health assessment will be seen within 24 hours of receipt of referral.

Referrals will be assessed as urgent if a young person has been placed on a paediatric / acute hospital ward as a result of:

- active self-harming and requires treatment
- is actively suicidal (has a plan and intent)
- has significant, rapid weight loss with a BMI of 14 or less
- is exhibiting active psychotic symptoms or unusual thought processes which are causing them to act in a manner which poses a risk to themselves or others

The local standards to be adhered to within working hours are detailed in the local flowcharts (Appendix 1).

5.3 Referrals

Referrals are expected to be received from the relevant ward at the earliest opportunity to enable the CAMHS to plan. Referrals can be made by telephone as detailed below pending the progression of secure email.
5.3.1 Receipt of referrals

All referrals received by CAMHS are directed to the Single Point of Access (SPA) or duty worker for triage in accordance with the locality operating procedure for the SPA/duty worker in hours (Section 5.3.3 and 5.3.5 below) and in accordance with the CAMHS Out of Hours SOP (Section 5.3.4 and 5.5.2 below).

5.3.2 Monitoring of Referrals

The Team Manager/Paediatric Liaison Nurse of the local CAMHS team will be responsible for collating referral data and information regarding all admissions to the acute hospital within their locality.

5.3.3 Triage

Triaging is a clinical function which aims to assess and categorise the urgency of the referred mental health related problem. This role is performed by the CAMHS SPA/duty worker on a daily basis between the hours of 09.00 and 17.00. A robust system is in place for the effective triage of all referrals received within 24 hours.

CAMHS will support the acute general hospital by offering advice and or assessment to support decision making regarding the safe discharge of children and young people.

5.3.4 Triage Out of Hours

CAMHS provide an out of hours service as detailed in section 5.5.2

5.3.5 Intoxication by Drugs and or Alcohol

Alcohol and drug intoxication may influence a person’s mental state presentation and may imitate or mask symptoms of an underlying mental disorder.

The presence of alcohol and/or drug intoxication does not preclude early assessment, although it may indicate the need for further assessment when the person is no longer intoxicated or under the influence of drugs.

Consideration as to whether the child or young person has the capacity to consent to an assessment, due to being under the influence of alcohol or drugs at the point of request, needs to be taken account of. Equally the level of disturbance to the child or young person’s presentation and associated risk should be a critical consideration.
5.4 Consent and parental responsibility

Parental responsibility means the rights and responsibilities that parents have in law for their child, including the right to consent to medical treatment for them, up to the age of 18 in England.

5.4.1 Establishing who has parental responsibility

Those with parental responsibility will usually, but not always, be the parents of the child or young person. Other people may acquire parental responsibility. Where the parents are not married it will be necessary to ascertain whether the father has gained parental responsibility.

Practitioners should always check with those caring for the child or young person whether any Child Arrangements Orders, Parental Responsibility Agreements or orders, or Special Guardianship Orders have been obtained.

Where children or young people are ‘Looked After’ by the Local Authority it will be important to establish whether they are subject to a care order (Section 31 Children Act) or are being voluntarily accommodated by the Local Authority, to establish who has parental responsibility. Where the Local Authority has parental responsibility they must always be informed of the admission and assessment.

5.4.2 Consent in relation to children and young people

It is good practice to involve the child or young person’s parents and/or others involved in their care in the decision-making process, if the child or young person consents to information about their care and treatment being shared.

5.4.3 Children under 16

Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. The test for children under 16 is determined by considering whether they are “Gillick competent”. (Appendix 2: Gillick Competence)

5.4.4 Young People (16 and 17 year olds)

The Mental Capacity Act applies to people aged 16 and over so young people must be assumed to have capacity to make the decision about a proposed admission / treatment unless it is established that they lack capacity. (Appendix 3: Mental Capacity Act 2005)

However, there may be times when a child or young person’s wish to withhold information from parents must be overridden.

5.4.5 Consent to the care regime during admission

The decision whether the child or young person consents to their care regime, or if it amounts to a deprivation of liberty, must be kept under regular review. A significant factor to be considered is the scope of parental responsibility and the level of supervision e.g. what is usual for a young child would not usually be an
acceptable restriction for a 17 year old. This is particularly significant where for example the risk assessment and care plan indicates that close observation/supervision is required (e.g. to manage risk to self and / or others).

CAMHS should advise the admitting ward MDT they will need to consider and apply developments in case law and may need to seek safeguarding/ legal advice in respect of individual cases to ensure the care of the child is delivered within the appropriate legal framework.

CAMHS staff should seek advice and guidance as required though clinical and managerial supervision, the Trust Safeguarding team and via the CAMHS On call Manager Out of Hours.

Approved Mental Health Professionals will also have access to legal advice via the Local Authority.

5.5 Assessment prerequisites

The admitting ward staff are required to:

- Confirm who has parental responsibility
- Assess the competence/capacity of the child/young person to consent to and participate in a mental health assessment
- Obtain consent for referral and/ or discuss with CAMHS those rare cases where consent cannot be secured to ensure the child/ young person is assessed within the appropriate legal framework
- Agree a suitable time for assessment and make all attempts to have a person with parental responsibility present for any child/ young person being assessed if appropriate
- Ensure a member of the ward team is available to provide a handover of reliable clinical information to inform the assessment
- Confirm that the child/ young person is ‘medically fit’ for assessment having excluded toxicity or organic pathology as a cause of the presenting problem

*(For the purpose of this SOP, ‘Medically fit’ is described as having completed all tests and treatment pertinent to the physical presenting problem and being suitably alert to participate in the assessment as in 5.3.5 and 5.7)*

5.5.1 Assessment Pathway: Attending the ward following admission in working hours

It is the responsibility of the locality Paediatric Liaison Nurse or Intensive Community Support pathway CAMHS practitioner to conduct a mental health and risk assessment on the paediatric/ acute hospital ward in their locality irrespective of the child’s usual place of residence.
In the event that the child/young person has an allocated care coordinator/CAMHS lead professional and they are available to undertake an assessment they may accept responsibility to do this themselves within the agreed timescales.

Assessment should be undertaken by a single clinician except in exceptional circumstances where there is a complex presentation.

The CAMHS clinician that conducts the assessment will:

a) Complete a FACE risk assessment (as a minimum) for all children/young people seen.

The purpose of the assessment is:

- to determine whether the young person is mentally fit for discharge to an agreed community setting and will no longer pose an unacceptable level of risk to themselves and/or others
- to establish a risk management plan for young people deemed fit for discharge
- to establish if parents/carers are able to implement the support and risk management plan
- to determine the risk management plan for a young person not deemed fit for discharge
- to ensure the risk assessment and risk management plan is clearly communicated and recorded in the young person’s file on the ward and also the CAMHS Electronic Patient Record

b) Adopt a collaborative approach to care and risk planning ensuring the child or young person, parent or carer and or legal guardian are involved and agree to the plan in consultation with the admitting ward where continued admission is agreed.

c) Inform the admitting ward’s Multi-Disciplinary Team/manager where the child or young person, parent or carer are not in agreement with the care plan/risk management proposed.

d) Record a clear plan of care in the child or young person’s file on the admitting ward at the point of assessment and ensure this is shared with the child or young person, parent or carer and or legal guardian. (Appendix 4)

e) Record the full assessment and outcome in the child or young person’s file on the admitting ward and also onto the CAMHS Electronic Patient Record/SystmOne).

f) Issue the child or young person and their family, with a crisis card pending a more substantive written care/crisis plan being agreed. (Appendix 5)

g) Contribute to Multi-Disciplinary/multi-agency decision making and
discharge planning for the child/ young person.

- Where this is at the point of initial assessment this is typically undertaken by the assessing clinician as the CAMHS representative (with support from CAMHS team manager/ pathway lead/ Consultant Psychiatrist as required). Where admission has been prolonged (i.e. over 72 hours) or the presentation is more complex (e.g.: safeguarding concerns, elevated risk factors) CAMHS will ensure the most appropriate CAMHS representatives attend any discharge planning meetings convened by the acute general hospital. See 5.6.1 and 5.6.2

h) Add a face-to-face contact to their staff calendar

i) Take on the role of care co-ordinator (for those cases with no current allocated care coordinator/ CAMHS lead professional) and ensure that they are allocated on the care network (SystmOne).

j) Complete a first contact ‘Current View’ form

k) Communicate the outcome of the assessment within 5 working days in writing to the child or young person’s GP as a minimum. Copies of this letter should be sent to the child or young person and/or their legal guardian in accordance with Trust policy for Copying Letters to Service Users.

l) Where there are identified safeguarding concerns and/or the child or young person has an allocated Social Worker, the details of the assessment/ outcome and risk management plan should be shared with the allocated Social Worker in accordance with Trust/ Local Safeguarding Children Board Policies.

5.5.2 Attending the ward following admission Out of Hours (in accordance with the SOP for CAMHS Out of Hours)

- Staff are expected to undertake assessments in line with Section 5.5.1 (a – h and l ) however there are process differences as below:

- Referring agencies will contact Tickhill Road Hospital switchboard (01302 796000) in the first instance, who will then contact the on call clinician. CAMHS clinicians will contact the referrer and triage the referral by telephone to determine suitability and necessity to attend the ward to undertake an assessment.

- CAMHS clinicians will assess all young people up to the age of 16 years. For young people between the ages of 16 years and 18 years the Locality Access Teams may conduct assessments without CAMHS clinicians, unless there are complex presentations. Where a young person aged 16 or 17 years has been admitted to a general hospital ward and an assessment is deemed necessary a joint assessment will be completed by the CAMHS on call clinician and the Access Team worker.
The CAMHS on call record should be completed for all out of hours contacts, including those where the child or young person has not been assessed.

All patient records should contain the child or young person’s name, date of birth and NHS number.

A copy of the CAMHS on call record should be uploaded onto SystmOne if the patient is known. If the patient is not known then the information will be emailed through to the locality team the next working day.

A FACE risk assessment and assessment document should be completed for all children and young people who have been assessed. This should be uploaded to SystmOne or emailed to the locality team.

The locality CAMHS team must be informed of any assessment the following morning.

Correspondence to the child or young person, parent or carer and or legal guardian and GP will be followed up by the locality team within 1 working week. This will not be the responsibility of the assessing out of hours clinician.

Following an out of hour’s assessment, the clinician is responsible for handing over the information to the relevant team the next day/ as soon as practicably possible. Information about children or young people who are already known to service should be passed to the lead clinician, or if they are not available, the clinical lead/ team manager for the relevant team.

For those children or young people who are “Looked After” ensure that there is liaison with the relevant Local Authority throughout the assessment and decision making process.

The following handover process should be adhered to for those children and young people who are presenting to service for the first time or are not currently in receipt of a service:

**Rotherham:**
SPA Team
Rotherham CAMHS
Kimberworth Place
Tel: 01709 304808
E-mail: rotherhamcamhsadmin@nhs.net

**Doncaster:**
SPA Team
Doncaster Child and Adolescent Mental Health Service
Tel: 01302 796191
Email: rdash.doncastercamhs@nhs.net
Children and young people currently in receipt of services should be directed to the lead professional/ Care Coordinator. In the absence of the lead professional/ Care Coordinator, the Team Manager or Paediatric Liaison Nurse should be informed.

**Rotherham:** 01709 304808

**Doncaster:** 01302 796191

**North Lincolnshire:** 01724 408460

Where psychiatric medical assessment is required, this must be clear within the handover of the case and further information may be required from the appropriate psychiatrist.

5.6 **Decision and outcome pathway:** Discharge of the child or young person into the community

- Where possible the clinician/ care coordinator (where known to the service) will be required to review the child or young person again within 7 working days following discharge, as per NICE guidelines. This may be sooner dependent upon presenting need and risk factors and may require a joint assessment with a Medical team member. Follow up contact may be in person or by telephone/ alternative method as agreed with the young person or family.

- Where the clinician/ Care Coordinator (where known to the service) is not available to undertake the 7 day review, it is the responsibility of the assessing worker to ensure that the child or young person and parent/ carer/ legal guardian are clear as to who will undertake this assessment. This may be a paediatric liaison nurse, or member off the intensive community support pathway. Information should be provided to the child or young person and parent/ carer/ legal guardian as to when and how to contact the service in the interim (crisis card). This should be recorded clearly in the electronic patient record.

- Where the 7 day follow up appointment indicates on-going care is required the child or young person and their parent/ carer/ legal guardian must be clear about who is their allocated Care Coordinator. The Care Coordinator must be named and allocated by the CAMHS within 10 working days of referral by the admitting ward.

5.6.1 **Decision and outcome pathway:** Where the child/ young person is not fit for discharge and remains on the ward

There are occasions where a child or young person may have a brief admission
and in more rare circumstances have a prolonged stay in an acute general hospital but also have on-going mental health needs. This may be due to co-existing or complex physical health needs and or delay in sourcing a suitable place for transfer or discharge. It is essential that the child or young person’s mental health and wellbeing is promoted and recovery maximised though on-going assessment and treatment by the local CAMHS during this time.

If on assessment the child or young person is not fit for discharge and remains on the ward, the following minimum standards will apply:

- Daily telephone contact with the ward by the Care Coordinator/ Paediatric Liaison Nurse/ intensive community support worker as per the local arrangement is expected. Details of the discussion and any decisions taken must be recorded in the CAMHS electronic patient record.

- Daily discussion of cases that are not discharged from the wards will take place with the CAMHS medical staff, as necessary.

- Face-to-face appointments must take place at no longer than 72 hourly intervals (Monday – Friday) unless agreed otherwise. Where visits are not required at this frequency this must be agreed in liaison with the ward manager/ MDT and the reasons documented in the clinical record.

- CAMHS staff will ensure that the ward is provided with a written initial care plan at the point of assessment to include (see Appendix 4):
  - An outline of the identified problem and core principles of care
  - Any observation required, for what purpose and describe how this should be undertaken (e.g. frequency, proximity, role of parents/ carers/ legal guardian)
  - Frequency of visits planned by CAMHS workers
  - Overview of Risk factors/ triggers to risk and management plan including safeguarding concerns
  - Information where the child or young person/ parent/ carer/ legal guardian do not consent to the care regime

- The child or young person, parent/ carer/ legal guardian should be provided with a crisis card (see Appendix 4):

- This care plan should be reviewed within a maximum of 7 working days and amended/ updated as necessary. It should be agreed with the child or young person, parent/ carer/ legal guardian (and ward staff for all children and young people who remain as an inpatient)

- A written copy of the full CAMHS FACE risk assessment should be shared with the ward within 3 working days for all children and young people who remain as an inpatient
CAMHS staff will be required to provide support to the paediatric nursing and medical staff. They should be clear about the risks and communicate this effectively to the paediatric staff highlighting what they should do if the risk changes, both in and out of hours.

CAMHS staff will be required to progress any referral to Tier 4 inpatient services in a timely manner, update the admitting ward with regard to progress and escalate concerns to NHS England regarding delays.

CAMHS/ Admitting Ward staff should contact the relevant trust’s safeguarding team for advice/ support where there is a safeguarding concern. Any safeguarding referrals must be completed at the point of assessment by CAMHS/ Admitting Ward in accordance with Trust/ Local Safeguarding Children Board Policies. This will include escalation of concerns where discharge is delayed pending review by another agency e.g. Local Authority Children Services/ Tier 4 providers.

5.7 Assessment under the Mental Health Act

There are situations where a child/ young person may require, either immediately (urgently) or as part of an assessment (routinely), a Mental Health Act assessment to be carried out. Approved Mental Health Professionals are employed within the Adult Access Teams and they will follow the Trust agreed pathway for dealing with Mental Health Act assessments including those for children and young people.

Mental Health Act Assessments are divided into ‘unplanned’ or ‘planned’.
Unplanned Mental Health Act Assessments - where a response is expected that day include the following:

- Section 136
- Section 135
- Section 2
- Section 3
- Section 4

It is less likely that the adult access team will be included in Planned Mental Health Act Assessments for children and young people as these should be provided by CAMHS community and Tier 4 staff however these would include the following:

- Section 5(2)
- Section 2 to 3
- Cases known to the treatment teams such as Early Intervention in Psychosis (including section(s) 2 and 3, section 135)
- Community Treatment Orders
- Guardianship

The Mental Health Act: Code of Practice 2015 (14.56) makes reference to the role of the Approved Mental Health Professional (AMHP) and states:

“Where patients are subject to the short term effects of alcohol or drugs (whether
prescribed or self-administered) which make interviewing them difficult, the AMHP should either wait until the effects have abated before intervening the patient or arrange to return later. If it is not realistic to wait because of the patient’s disturbed behaviour and the urgency, the assessment will have to be based on whatever information the AMHP can obtain from reliable sources. This should be made clear in the AMHP’s record of the assessment.”

5.8 Escalation of concerns/ conflict resolution

Any member of staff who has concerns regarding the application of this policy or encounters conflict which they are unable to resolve with regard to the care and treatment of a child/ young person within the scope of this policy should:

- Raise initial problems with the locality team manager/ paediatric liaison nurse/ or on call Manager out of Hours.
- If at this point it cannot be resolved then the manager/ clinical lead will pass the information on to the Service Manager of CAMHS.

If problems still persist and a resolution has not been sought then this will be escalated to the Children’s Care Group Director.

6. TRAINING IMPLICATIONS

“There are no specific training needs in relation to this policy, but the following staff will need to be familiar with its contents:

All CAMHS clinical staff and any other individual or group with a responsibility for implementing the contents of this policy. Each CAMHS locality team will make the team aware of any new/ updated policy via team meetings and ensure this is covered in local induction for new starters.

As a Trust policy, all staff need to be aware of the key points that the policy covers. Staff can be made aware through: Trust wide email.

7. MONITORING ARRANGEMENTS

<table>
<thead>
<tr>
<th>Area for monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with the standards within this Policy</td>
<td>Review of any complaints/ concerns escalated/ action plans that relate to the admission of children and young people to paediatric ward</td>
<td>Team Managers/ Paediatric Liaison Nurse</td>
<td>Children’s care group Governance Groups</td>
<td>6 monthly</td>
</tr>
</tbody>
</table>
8. **EQUALITY IMPACT ASSESSMENT SCREENING**

The completed Equality Impact Assessment for this Policy has been published on this Policy’s webpage on the Trust website.

8.1 **Privacy, Dignity and Respect**

<table>
<thead>
<tr>
<th>Indicate how this will be met</th>
</tr>
</thead>
<tbody>
<tr>
<td>No issues have been identified in relation to this policy.</td>
</tr>
</tbody>
</table>

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

8.2 **Mental Capacity Act**

<table>
<thead>
<tr>
<th>Indicate How This Will Be Achieved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)</td>
</tr>
</tbody>
</table>

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

9. **LINKS TO ANY ASSOCIATED DOCUMENTS**

The following policies can be located via the following link: https://www.rdash.nhs.uk/category/publications/policies/clinical-policies/

- Clinical Risk Assessment and Management
- Management of Self Harm in Primary and Specialist Care Services
- Safeguarding Children’s Policy
- Mental Capacity Act Policy
- Section 136 Protocol
- Children Who DNA and or Disengage
- Standard Operating Procedure for Children and Young People’s
Mental Health Service for Children and Young People that are placed in Tier 4 establishments

- Standard Operating Procedure for Children and Young People’s Mental Health Service Out of Hours Service (CAMHS)
- Mental Capacity Act and Deprivation of Liberty Safeguards (DOLs) information
- Copying Letters To Patients Policy

10 REFERENCES


11 APPENDICES

Appendix 1 – Locality Pathways in Working Hours
Appendix 2 – Gillick Competency
Appendix 3 – Mental Capacity Act
Appendix 4 – Initial Care Plan and Risk Overview following Assessment of a Child/Young Person on an Acute Hospital Ward
Appendix 5 – Crisis Card (By Locality)
Appendix 1

Locality Pathways in Working Hours

Doncaster in Hours Overarching pathway
Acute hospital manages any acute medical/physical problems and excludes toxicity or organic pathology as cause
Admitting Ward refer to CAMHS service

In hours 09.00-17.00 Mon – Fri (01302 796191)
Staff can also discuss with Paediatric Liaison Nurse who provides support to the paediatric unit/acute hospital wards during the hours of 09.00 – 17.00 Monday to Friday.
CAMHS respond within 24 hours to admitting ward unless mutually agreed otherwise (i.e. not medically fit)
CAMHS Team advise on appropriate admission or discharge and support

North Lincolnshire in Hours Overarching pathway
Acute hospital manages any acute medical/physical problems and excludes toxicity or organic pathology as cause

Admitting Ward refer to CAMHS service

In hours 09.00-17.00 Mon – Fri (01724 408460)
CAMHS urgent criteria is a met & response time of within 24 hours to admitting ward unless mutually agreed otherwise (i.e. not medically fit)
CAMHS Team advise on appropriate admission or discharge and support
Rotherham in Hours Overarching pathway

Acute hospital manages any acute medical/physical problems and excludes toxicity or organic pathology as cause

Admitting Ward refer to CAMHS service

Staff can also discuss with Paediatric Liaison Nurse who provides support to the paediatric unit / acute hospital wards during the hours of 09.00 – 17.00 Monday to Friday.

In hours 09.00-17.00 Mon – Fri (01709 304808)

CAMHS urgent criteria is met & response within 2 hours to admitting ward unless mutually agreed otherwise (i.e. not medically fit)

CAMHS Team advise on appropriate admission or discharge and support
Rotherham Pathway for Child Presenting with Act of Self-Harm

A Child Aged 8-17 Presents with Act of Self Harm
E.g. Self poisoning, cutting, other act of Deliberate harm

No ongoing medical Care required

ED assess for and manage any medical or acute physical problems if Present

Requires medical care

Aged under 16 years:
Admit to Paediatric Ward and assess for 1:1 supervision

Aged 16-17 years:
Admit to Paediatric Ward and assess for 1:1 supervision

CAMHS/Access Team decide on appropriate mental health admission or discharge. Assessing Practitioner to notify the 0-19 SPA Service of assessment on 01709 423333

Mon-Fri 9-5 (Not Bank Holiday)
CAMHS Liaison Nurse
07901165265
If not available contact the CAMHS SPA team on 01709 304838
CAMHS attendance at ED is expected unless mutually agreed otherwise.
If over 2 hours – admit to Children Ward and assess for 1:1 supervision requirement

Admit the child and refer to CAMHS for assessment.
Contact Paediatric Liaison/SPA Team Mon-Fri 9-5, Weekends/OOH Contact Switchboard, number 01302 796000
Pediatrics review/discussion for any Safeguarding concerns and possible medical input as necessary.

Adult Medics consider any Safeguarding concerns and provide medical input as necessary. Advice can be sought from Paediatrician if required.

A child in these circumstances with challenging behaviour may require extra support, including the use of TRFT security: the use of Security is not to be in place of nursing care, a member of TRFT nursing staff would still need to be present. This is not a reason for non-acceptance to the Paediatric Ward.
Gillick Competency

Mental Health Act: Code of Practice 2015 (19.34 – 19.37)

Establishing Gillick competence?

19.34 Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made. This is because in the case of Gillick, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the competence to consent to that intervention. This is sometimes described as being “Gillick competent”. A child may be Gillick competent to consent to admission to hospital, medical treatment, research or any other activity that requires their consent.

19.35 The concept of Gillick competence is said to reflect the child’s increasing development to maturity. The understanding required for different interventions will vary considerably. A child may have the competence to consent to some interventions but not others. The child’s competence to consent should be assessed carefully in relation to each decision that needs to be made.

19.36 When considering whether a child has the competence to decide about the proposed intervention, practitioners may find it helpful to consider the following questions:

- Does the child understand the information that is relevant to the decision that needs to be made?
- Can the child hold the information in their mind long enough so that they can use it to make the decision?
- Is the child able to weigh up that information and use it to arrive at a decision?
- Is the child able to communicate their decision (by talking, using sign language or any other means)?

19.37 A child may lack the competence to make the decision in question either because they have not as yet developed the necessary intelligence and understanding to make that particular decision; or for another reason, such as because their mental disorder adversely affects their ability to make the decision. In either case, the child will be considered to lack Gillick competence.
Mental Capacity Act 2005

The Mental Capacity Act (MCA) in general, applies to individuals aged 16 years and over and empowers individuals to make their own decisions where possible and protects the rights of those who lack capacity. Where an individual lacks capacity to make a specific decision at a particular time, the MCA provides a legal framework for others to act and make that decision on their behalf, in their best interests, including where the decision is about care and / or treatment.

Principles of the MCA

Principle One

A person must be assumed to have capacity unless it is established that they lack capacity.

Principle Two

A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

Principle Three

A person is not to be treated as unable to make a decision merely because they make an unwise decision.

Principle Four

An act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests.

Principle Five

Before the act is done, or the decision is made, regard must be had to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

It is important for professionals to be aware that individuals with a mental disorder do not necessarily lack capacity. The assumption should always be that a patient has capacity unless it is established otherwise in accordance with the MCA.

Patients lacking capacity

A person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

The above definition contains both a “diagnostic test” and a “functional test”. The diagnostic test determines whether the individual has an impairment of or a disturbance in the functioning of the mind or brain. The impairment or disturbance can be temporary or permanent, but if it is temporary, the decision-maker should justify why the decision cannot wait until the circumstances change.

The functional test determines whether the individual is unable to make the specific decision in question themselves because of the impairment or disturbance. Both tests must
be satisfied for an individual to be deemed to lack capacity to make the specific decision in question at the material time.

A person is unable to make a decision for themselves if they are unable to do any one of the following:

- Understand information which is relevant to the decision to be made
- Retain that information in their mind
- Use or weigh that information as part of the decision-making process, or
- Communicate their decision (whether by talking, sign language or any other means)

As capacity relates to specific matters and can change over time, capacity should be reassessed as appropriate over time and in respect of specific treatment decisions. Decision-makers should note that the MCA test of capacity should be used whenever assessing a patient’s capacity to consent.

**Best Interests** is a core principle that underpins the Act. In brief, it stresses that any act done or decision made on behalf of an individual who lacks capacity, must be done or made in their best interests. This principle covers all aspects of financial, personal welfare, health care decision-making and actions.

Everything that is done for or on behalf of a person who lacks capacity must be in that person’s best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person’s best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which must be considered by the decision maker. Also, carers and family members have a right to be consulted. In order to document and structure this process in a formal and clear way, RDaSH in collaboration with the Local Authority have developed a best interest checklist ‘Pro-forma (Form MCA 2)’ as a means of ensuring that all the statutory requirements are covered.

Staff should also refer to the Trust’s Mental Capacity Act 2005 Policy.

**Younger People**

The Act applies to people of 16 or over who lack capacity to make their own decisions. Most of the provisions of the Act apply to young people of 16 and 17 years old. Decisions relating to treatment of young people of 16 and 17 who lack capacity must be made in their best interests in accordance with the principles of the Act. The young person’s family and friends should be consulted where practicable and appropriate. However, a person needs to be 18 or over to make an advance decision.

The Children Act 1989 covers the care and welfare of children in most situations. The Mental Capacity Act applies to children under 16 years in two ways:

- The Court of Protection can make decisions about the property and affairs of a child where it is likely that the child will lack capacity to make those decisions when they reach 16 years old.
- The criminal offence of ill treatment or neglect applies to children who lack capacity.
- Decision-makers should ensure that where a capacity assessment is undertaken, this is recorded (see MCA1 Form) and where the young person lacks capacity the record of actions taken to make a best interest decision should be recorded on an MCA2 form.
A person must be assumed to have capacity unless it is established that they lack capacity to make a particular decision at the point in time the decision needs to be made.

A person's capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour. It is important to take all possible steps to try to help the person to make the decision themselves. An assessment should only be triggered if you have ‘reasonable belief ‘that the person may have difficulty making the decision. However where there is an impairment of or a disturbance in the functioning of the person’s mind or brain use of the Act should be considered.

<table>
<thead>
<tr>
<th>Name of Relevant Person</th>
<th>Reference number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Decision maker carrying out the Assessment</td>
<td>Role</td>
</tr>
<tr>
<td>Date assessment started</td>
<td>Team</td>
</tr>
</tbody>
</table>

As Decision maker you are assessing the person mental capacity to make this particular decision at this particular time. If there is more than one decision to be made they must be assessed and recorded separately.

Clearly state the decision to be made:

Do you need to involve anyone to help you to communicate with the person? Do you need anyone else to provide information or give their opinion? Please give the name and status of anyone who assisted with this assessment:

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
STAGE 1 - DETERMINING IMPAIRMENT OR DISTURBANCE OF MIND OR BRAIN

The Act requires assessors to have “reasonable belief” that a person lacks capacity in relation to a decision. If there is an established diagnosis of mental illness, learning disability, or some other condition then it is sufficient to confirm” impairment or disturbance of the mind”. You do not need to involve other professionals unless the assessment is complex, when they can be asked to assist or provide a diagnosis.

<table>
<thead>
<tr>
<th>Response</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If Yes record symptoms, behaviours and any relevant information</td>
<td></td>
</tr>
</tbody>
</table>

Q1. Is there an impairment of, or disturbance in the functioning of the person’s mind or brain? (e.g. symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term effects of brain damage, confusion, drowsiness or loss of consciousness due to a physical or medical condition)

Response

Yes

If you have answered YES to Question 1, PROCEED TO STAGE 2

If you have answered NO to Question 1, there is no such impairment or disturbance and thus THE PERSON DOES NOT LACK CAPACITY within the meaning of the Mental Capacity Act 2005

Sign/date this form, record the outcome within the person’s case records. DO NOT PROCEED ANY FURTHER.

STAGE 2 - ASSESSMENT

Having determined impairment or disturbance (Stage 1) and given consideration to the ease, location and timing; relevance of information communicated; the communication method used; and others involvement, you now need to complete your assessment and form your opinion as to whether the impairment or disturbance is sufficient that the person lacks the capacity to make this particular decision at this moment in time. You must ensure that the information has been provided in a way that the person is able to understand?

<table>
<thead>
<tr>
<th>Response</th>
<th>You must provide evidence of the steps you have taken as to how you came to your opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Q2. Is the person able to understand the information relevant to the decision to be made? Do they understand the nature and effect of the decision and the reason why it is needed? Are they able to understand the consequences of making or not making the decision?
Q3. Is the person able to **retain** the information for long enough to make an effective decision? People who can only retain the information for a short time must not be presumed to lack the capacity to decide - it depends on the importance of the decision to be made.

Q4. Is the person able to **weigh up** the information to arrive at a decision? Sometimes people can understand information but impairment can and stop them using it.

Q5. Is the person able to **communicate** their decision?

All steps must be taken to aid communication.

If you have answered **YES** consistently to Q2 to Q5, the person is considered on the balance of probability, to **HAVE** the mental capacity to make this particular decision at this point in time.

Sign/date this form and record the outcome within the person’s case records.

**DO NOT PROCEED TO MAKE A BEST INTERESTS DECISION**

If you have answered **NO** to any of the questions, proceed to Q6.

**Please provide details of the outcome of your assessment**

Q6. Overall, do you consider on the **balance of probability**, that there is sufficient evidence to indicate that the person lacks the capacity to make this particular decision at this point in time?

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date assessment completed</th>
</tr>
</thead>
</table>

If the person is unable to make the decision themselves, is there someone with a Registered EPA, LPA or a Court appointed Deputy, with powers to make the decision which needs to be made?

If **Yes**: - They make the decision. Record their details on Appendix 1. Authorised decision makers will only be able to make decisions on matters covered by their EPA, LPA or Court order, although they should still be consulted when a best interest decision on other matters needs to be made.

If **No**: - You are able to proceed to make Best Interests decision on their behalf but should consider at this stage whether or not an Independent Mental Capacity Advocate (IMCA) needs to be appointed.
**FORM MCA2**

Record of actions taken to make a best interest decision

<table>
<thead>
<tr>
<th>Name Of Service User</th>
<th>Reference number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name Of Decision Making Officer</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Date best interest decision making process started</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please give the name and status of anyone who assisted with making this best interest decision

<table>
<thead>
<tr>
<th>Name</th>
<th>Status</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Details of the decision to be made on behalf of person who lacks capacity

PART 1 DETERMINING LACK OF CAPACITY

Every adult should be assumed to have the capacity to make a decision unless it is proved that they lack capacity. An assumption about someone’s capacity cannot be made merely on the basis of a Service Users age or appearance, condition or aspect of his or her behaviour.

<table>
<thead>
<tr>
<th>Response</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Has the Service User been determined as lacking capacity to make this particular decision at this moment in time?

**Guidance:** give date of capacity assessment (form MCA1)

If you have answered **YES**, PROCEED TO PART 2 of this document.

If you have answered **NO**, identify decision(s) to be made and complete capacity assessment.
**PART 2 – DETERMINING BEST INTERESTS**

All steps and decisions taken for someone who lacks capacity must be taken in their best interests.

<table>
<thead>
<tr>
<th>Q1. Avoid Discrimination – Guidance</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you avoided making assumptions merely on the basis of the Service Users age, appearance, condition or behaviour?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2. Relevant Circumstances – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you identified all the things the Service User would have taken into account when making the decision for themselves?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3. Regaining Capacity – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you considered if the Service User is likely to have capacity at some date in the future and if the decision can be delayed until that time?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4. Encourage Participation – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you done whatever is possible to permit and encourage the Service User to take part in making the decision?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5. Special Considerations – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6. The Persons Wishes – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has consideration been given to the Service Users past and present wishes and feelings, beliefs and values, that would be likely to influence this decision?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q7. Written statements – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you considered any written statement made by the person when they had capacity?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q8. Consult Others – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you where practicable and appropriate, consulted and taken into account the views of others including those engaged in caring for the Service User, relatives and friends, persons previously named by the Service User, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q9. IMCA – Guidance:</th>
<th>Response</th>
<th>Details of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the decision relates to serious medical treatment including DNR</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### PART 2 – DETERMINING BEST INTERESTS

All steps and decisions taken for someone who lacks capacity must be taken in their best interests.

<table>
<thead>
<tr>
<th>Q10. <strong>Avoid Restricting Rights</strong> – Guidance: Has consideration been given to the least restrictive option for the service user?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q11. <strong>Other Considerations</strong> – Guidance: have you considered factors such as emotional bonds, family obligations that the person would be likely to consider if they were making the decision?</td>
</tr>
</tbody>
</table>

### Part 3 - FINAL DECISION

Q12. Having considered all the relevant circumstances, what decision/action do you intend to take whilst acting in the Best Interests of the Service User?

| Signature: | Date: |
### INITIAL CARE PLAN AND RISK OVERVIEW FOLLOWING ASSESSMENT OF A CHILD / YOUNG PERSON ON AN ACUTE HOSPITAL WARD

<table>
<thead>
<tr>
<th>NAME OF CHILD:</th>
<th>DOB:</th>
<th>NHS No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing Clinician:</td>
<td>Date:</td>
<td>Signature:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care Coordinator if known to service:</td>
</tr>
</tbody>
</table>

#### Identified Needs

<table>
<thead>
<tr>
<th>Identified Needs</th>
<th>Interventions Required</th>
<th>By whom and timescale / frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Describe any observation required and for what purpose

<table>
<thead>
<tr>
<th>Describe any observation required and for what purpose</th>
<th>Describe how this should be undertaken (e.g. frequency, proximity)</th>
<th>By whom: (e.g. role of parents / carers for child's safety)</th>
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#### Care regime and consent discussed with:

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<th>Name:</th>
<th>Summary:</th>
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#### Crisis Card / Information Given

<table>
<thead>
<tr>
<th>Crisis Card / Information Given</th>
<th>Yes:</th>
<th>No:</th>
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#### Discussed with Trust Safeguarding team?

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<thead>
<tr>
<th>Discussed with Trust Safeguarding team?</th>
<th>Yes:</th>
<th>No:</th>
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#### Is a Safeguarding referral required?

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<tr>
<th>Is a Safeguarding referral required?</th>
<th>Yes:</th>
<th>No:</th>
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#### Who has agreed to undertake this?

<table>
<thead>
<tr>
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<th>Name:</th>
<th>Role:</th>
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### Risk Overview: what may happen a description the potential situation, the triggers early warning signs and relapse indicators

### What may happen:
<table>
<thead>
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<th>Triggers:</th>
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<tbody>
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<td>Indicators:</td>
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<tr>
<th>Actions to be taken</th>
<th>By whom and timescale / frequency</th>
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Appendix 5: Crisis Card side 1 (By Locality)

North Lincolnshire Children and Young People’s Mental Health Service Information and Crisis Card

Who can you contact if you need to get help in a mental health crisis?
Between 9am-5pm you can contact:
Your Care Co-Ordinator: ___________________________ Contact Number: ___________________________
The Duty Team on: 01724 408460

Please note the services are shut on public bank holidays but the out of hours service continues to operate.
Out of Hours is after 5pm and at weekends where for a mental health crisis access to support is at your local Accident and Emergency department.

If you are aged 16 years and over you can also contact the North Lincolnshire Crisis Team on: 01724 382015
If someone is in immediate danger call 999

Crisis Card side 2

Rotherham Children and Young People’s Mental Health Service Information and Crisis Card

Who can you contact if you need to get help in a mental health crisis?
Between 9am-5pm you can contact:
Your Care Co-Ordinator: ___________________________ Contact Number: ___________________________
The Duty Team on: 01709 304808

Please note the services are shut on public bank holidays but the out of hours service continues to operate.
Out of Hours is after 5pm and at weekends where for a mental health crisis access to support is at your local Accident and Emergency department.

If you are aged 16 years and over you can also contact the Rotherham Crisis Team on: 01709 302670
If someone is in immediate danger call 999

Children and Young People’s Mental Health Services

Appendix 5: Crisis Card side 1 (By Locality)