The Royal Wolverhampton NHS Trust

CP63

Paediatric Self-Harm Policy (CAMHS and Acute Hospitals in Black Country)

Contents

Appendices

1.0 Policy Statement (Purpose / Objectives of the policy)

This policy has been co-produced between CAMHS Crisis Intervention & Home treatment team (BCHFT) and acute hospitals in the Black Country. It is intended to assist clinicians who provide care and treatment to children presenting to Emergency departments (ED), and walk-in centres and any in-patient facility in an acute hospital, following an act of self-harm, or where there are concerns about potential self-harm / risk to self/others or other mental health presentation. This policy is to apply across the Black Country (BCHFT) and pertains to all Children and young people up to the age of 18 years.

Where relevant adolescents between the ages of 16-18 years are given the choice in the Emergency department (ED) of where they want to be admitted (adult or children ward). Irrespective of the young person's choice, they will be seen for mental health assessment by the local CAMHS crisis intervention and home treatment team (CIHTT).

The expected outcomes of this policy are to:

- Reduce the risk of self-harm incidents in children and young people (CYP) being cared for in the Trust.
- Ensure CYP admitted with self-harm are safely managed and discharged in collaboration with metal health services.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions and Abbreviations

Care Education and Treatment Review (CETR)
A review that is focused on Children and young people who either have been admitted or may be about to be admitted to a specialist mental health or learning disability hospital. It brings together the CYP, their family and people who commission and provide services (e.g. nurses, social workers, commissioners and other health, education and social care professionals) and other experts.

Children and Young People (CYP)
For the purpose of this policy, a person under the age of 18 years.

Children and Adolescent Mental Health Services (CAMHS)
Specialist mental health services for CYP under the age of 18 years.

Crisis and Home Intervention Team (CIHTT)
A service that provides a timely and effective service for children young people and their families who present in a mental health crisis.

Self-harm
A term used when someone injures or harms themselves on purpose rather than by accident. Self-harm is always a sign of something being seriously wrong' (Royal College of Psychiatrists, 2012).

People self-harm in many different ways: some more obvious than others. Common methods of self-harm include overdosing, cutting parts of the body and scratching. Less common and less obvious acts of self-harm may include hair pulling, ingesting dangerous substances, inserting objects into the body, or placing oneself in dangerous situations. Assessing clinicians must use the patient's intent as a guide to whether or not someone's actions should be considered as self-harm.

Suicide attempt:
An attempt to end one's life. The distinction between the attempted suicide and self-harm may not always be clear cut. For example, a person might take an overdose of prescribed medication to get some sleep or respite from current problems, but not be too bothered if they wake up. They don't plan to kill themselves, but they're too tired to think through the consequences.

3.0 Accountabilities

3.1 It is the responsibility of the **Chief Executive through the Chief Medical Officer** to promote the aims and objectives of this policy and to provide a suitable Governance framework to enable any incidents to be reported so that learning can be maximised and future incidents prevented.

3.2 **Matrons, Team Leaders and Heads of Services** are responsible for the implementation of this policy in their areas of responsibility including:

- Staff attending relevant Mental Health Mandatory Training;
- Incidents of self-harm being recorded on Datix and appropriately investigated;
- Staff receiving supervision following incidents in which they may feel traumatised.

3.3 **All practitioners** who independently consult with CYP must take immediate action to safeguard the person if they suspect self-harm or self-harm is disclosed to them. It is not adequate to simply rely on onwards referral.

3.4 **All staff** have a responsibility to take appropriate actions should a patient, member of the public or a staff member disclose self-harm or the intent to self-harm.

3.5 **Black Country Mental Health Foundation Trust (BCHFT)** has a responsibility to provide suitably qualified CAMHS team on site in line with contracted service. Including:

- Undertaking a mental health risk assessment and providing mental health follow up.
- Arranging a CAMHS inpatient bed if required.
- Arranging CETR if required
- Ensuring adequate clinically informed reviews if CYP remain on the ward (C&YP with registered GPs in the Black Country)

- Communicating with MH and social care teams out of the Black Country to ensure safe follow up, risk mitigation and prompt and appropriate discharge.
- Ensuring that parents, carers and Trust staff are kept informed of developments in the MH care of the CYP.

3.6 **All staff** have a responsibility to work collaboratively with each other including multi-agency for the benefit of the CYP in the care of the Trust.

3.7 **Medical teams** are responsible for the physical health and well-being of the child/young person, including:

- Assessing and treating any physical health consequence from the act of self-harm.
- Appropriate plans are also needed for any other need identified in physical health, e.g., arranging investigation, follow-up or referral to an appropriate specialist.
- Discharge of C&YP who present with emotional wellbeing mental health concerns in discussion with other agencies.

3.8 **Social Care Teams are responsible for** Assessing the psycho- social and safeguarding needs of CYP including:

- Putting appropriate measures in place to protect CYP of the Black Country.
- Supporting children and young in care with MH needs to be appropriately placed and prevent hospitalisation where possible.
- Liaising with any out of area social care providers when CYP are in residential care within the Black Country.

4.0 Policy Detail

The Mental Health pathways for CYP are provided in Appendices 1 (Emergency Department) and 2 (Inpatient care).

4.1 Initial Management of Risk and Communication (see also Appendix 1)

4.1.1 CYP must have mental health triage in the Emergency Department (ED) by the triage nurse (see Appendix 3 – Mental health triage) to briefly gauge their risk of self-harm, suicide, and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED. However, the medical needs of the child/young person are to be assessed and any urgent treatment administered.

4.1.2 Patients at medium or high risk of self-harm or of leaving before assessment and treatment are complete must be observed closely whilst in the ED. There must be documented evidence of either

continuous observation or intermittent checks (at least every 15 minutes), whichever is most appropriate. Referral must be undertaken to CAMHS CIHTT at the earliest opportunity. The patient will then be seen face to face in the ED department within 4 hours of referral for all referrals received before 18.00hrs. If medium or high risk CYP require medical interventions and admission.

4.1.3 If a young person states that they want to leave or decline treatment, then there must be documentation of the assessment of that patient's capacity to make that particular decision at that time, based on a face-to-face conversation and not rely on records from previous attendances. If they are not deemed to have capacity, then the parent/carer must sign a discharge against medical advice form if they are making the decision on behalf of the patient. A safeguarding referral must then be raised. If a patient is permitted to leave but requires a mental health assessment, then a telephone referral to notify the CAMHS CIHTT team must still take place. CIHTT will endeavour to contact the young person or parent/carer. If this happens out of hours, then a referral must be emailed to the CAMHS CIHTT team inbox and CAMHS Single point of access (SPA).

4.1.4 If a young person who is considered to be medium to high-risk mental health status leaves ED in an unplanned way before a mental health assessment has taken place, then the Missing patient policy (OP53) and Mental Health Act Administration (OP11) policy must be followed as appropriate**.**

4.1.5 When an ED doctor reviews a patient presenting with self-harm or a primary mental health problem, they must conduct a brief risk assessment of suicide and further self-harm and record the outcome of the assessment in the patient record.

4.1.6 From the time of referral, a member of CIHTT must either see the patient face to-face, or conduct a telephone triage and offer appropriate assistance, to both patient and referrer within four hours of the referral. Full assessment may be delayed if the patient is not yet medically stable for assessment.

4.1.7 Young people who have attended the ED for help with self-harm must receive a comprehensive biopsychosocial assessment with appropriate safety or care planning at every attendance, unless a joint ED/Psychiatric written management plan states that this is not necessary or unhelpful**.**

4.1.8 Details of any referral or follow-up arrangements must be documented in the patient's ED notes. Any assessment undertaken by CAMHS CIHTT must be documented in the ED notes and reflected as shared record entries**.**

4.2 Treatment and Admission of CYP with self-harm (see appendix 2)

4.2.1 CYP must be admitted under the On-call Consultant Paediatrician or Consultant Physician (if placed on an Adult Ward). Any further medical treatment as necessary is usually the priority.

4.2.2 In cases of substance misuse, the medical team must re-assess the CYP once they are no longer intoxicated or withdrawing from substances. Outpatient referral can be made to the appropriate locality substance misuse team if substance misuse is a significant concern. Referral can be made to CAMHS CIHTT if mental health concerns are identified

4.2.3 CAMHS CIHTT will phone all ward areas and ED from 8.00am to ascertain if any young person has been admitted or is awaiting CAMHS CIHTT in the ED. CAMHS CIHTT will complete the referral form with the ward when they call each morning (see Appendix 6). Any additional known information that maybe relevant for the CAMHS assessment (such as details of social care involvement) must be shared at this point. An approximate time of the assessment will be given to the ward at the point of referral so that parents and carers can be informed by the ward and attend the appointment as appropriate. Wards must take note of any CYP in care and identify the corporate parent or person with parental responsibilities. This may not be the biological parent identified on the Trust patient administration system (PAS).

4.2.4 The CYP must be medically fit for assessment prior to undertaking the mental health assessment. CYP who require medical treatment that is likely to last overnight, must be seen and assessed on the day that they are likely to be medically fit for discharge, rather than being assessed by CAMHS at the beginning of their admission and treatment. This practice will avoid unnecessary duplication of assessments. However, if the acute hospital is concerned about a young person's mental health presentation during this treatment intervention they can call the CAMHS CIHTT for consultation.

4.2.5 CAMHS CIHTT will undertake a mental health risk assessment with the CYP and parent/carer. Parents and carers (or person with parental responsibility) will be informed of assessment findings and the discharge plan once this has been discussed and agreed this with the consultant and nurse in charge.

4.2.6 Young people who do not wish parents/carers to be involved in the assessment will be assessed by the CAMHS clinician for mental capacity (16 years and above)/Gillick competence (under 16 years) please refer to CP06 consent policy. Upholding of these consents is based on clinical risk and must be recorded in the medical record.

4.2.7 All documents and narratives completed by the CAMHS Teams during the assessment will be copied into the acute trust patient record with clear advice around care, discharge and follow up. Medical records must reflect the view of the CYP/Parent/Carer and their agreement with the plan.

4.2.8 Liaison with other services such as children's social care must also be documented.

4.2.9 Parents/Carers are to be provided with relevant information and guidance by CAMHS CIHTT regarding how to maintain the CYP safety and reduce further acts of self-harm when discharged back

into the community. Any concerns regarding the ability to keep the CYP safe as expressed by parents/carers are to be duly addressed and the management of their concerns documented.

4.2.10 The ability to keep the CYP safe as expressed by parents/carers are to be duly addressed and the management of their concerns documented.

4.2.11 CAMHS CIHTT clinicians should consider if there is a need to hold a multi-agency pre-discharge planning meeting for those CYP who are considered high risk, have repeated mental health presentation or safeguarding concerns.

4.2.12 A follow-up with CAMHS CIHTT will be offered within 7 days.

4.2.13 Discharge will be coordinated by the acute Trust teams once they are aware of CAMHS CIHTT recommendations on discharge.

4.2.14 If discharge is not appropriate either due to ongoing risks, safeguarding concerns or need for further medical interventions then CAMHS CIHTT will review the CYP frequently as deemed clinically appropriate. In cases of delayed discharge follow escalation policy.

4.2.15 If additional staffing is required to support care plans whilst on the ward then an additional staffing form can be completed and submitted to commissioners for consideration (please see request form Appendix 7).

4.2.16 If there is disagreement between practitioners/agencies on the needs of the CYP, senior practitioners (e.g., the Consultant for the medical team) from all involved agencies must engage to find a solution and escalate to clinical lead withing the directorate if required. If a solution still can't be found then the exec lead for MH at the Trust must be informed in order to liaise exec-exec with the relevant organisation. The welfare and health needs of the CYP must be central to all decisions.

4.3 Actions in the event of a CYP self-harming on Trust premises

4.3.1 Patients admitted to hospital with mental health disorders or other causes of distress may pursue self-injurious behaviour in the hospital environment. Should this occur it is important that the patient's needs are reassessed, and appropriate care provided to prevent recurrence.

4.3.2 An Incident report should be completed whenever a patient self-harms in the hospital. The circumstances of the event should be clearly documented in the notes including the location, level of supervision, staff present at the time of the incident or those who discovered the self-harm had occurred.
Duty of candour should be considered and addressed as needed.

4.3.3 If a patient self-harms in hospital their medical needs must first be addressed. Appropriate first aid or ABC resuscitation should be provided by initial responders.

4.3.4 The patient should be brought to the attention of the medical team as needed to address their injuries. If the injury or action is life-threatening an emergency call (2222) should be placed to access the resuscitation team.

4.3.5 If the injury or action is not immediately life threatening the responsible team doctors should be notified. If the injury/action is outside of the usual team's expertise to manage, a referral should be made to the appropriate team (eg T&O for wound management, the medical team for overdoses in patients being managed by non-medical teams).

4.3.6 Patients who self-harm in hospital should have a review by the appropriate mental health team (Mental Health liaison if >18yrs, CAMHS crisis if <18yrs). A Mental Health Act assessment should be undertaken where appropriate and the mental health/mental capacity act used to ensure patient safety if this is required.

4.3.7 Any previous Mental health risk assessment should be re-visited by the ward staff to consider the level of supervision currently in place and whether additional support may be required.

4.3.8 In children and young people, a referral should be made to social care if this has not been done previously. Consideration should be given to safeguarding factors for children and adults who self-harm. If there is a safeguarding concern this should be reported to the appropriate safeguarding team and escalated in line with policy.

4.3.9 In the event of significant injury or death, staff members should be offered support by their managers and/or staff well-being services.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

Performed by Author as part of review process.

7.0 Maintenance

This policy will be kept under review by the CAMHS subgroup, accountable to the Children and Young Peoples 0-18 service. In the event of significant changes in practice it will require review, or routinely at 3 yearly intervals

8.0 Communication and Training

To be communicated to staff members via usual ward/departmental channels. Additional training not required

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Timings for CAMHS involvement - 4hrs in ED - 12 hrs in ward	Sarah Hogan	Rolling audit	Quarterly	CAMHS subgroup

Admissions awaiting tier 4 bed or social care placement	Sarah Hogan		Quarterly	CAMHS subgroup
Number of young people presenting to ED with self harm/suicidal ideation	Lorna Bagshaw	Audit	Quarterly	CAMHS subgroup
Duration of stay of young person with self harm/suicidal ideation (standard aimed for 90% less than 24 hours)	Kirsty Lewis (ward)/Sarah Blackburn (ED)	Audit	Quarterly	CAMHS subgroup
Any datixes relating to self harm on the ward/in ED	Kirsty Lewis (ward)/Sarah Blackburn (ED)	Reporting	Quarterly	CAMHS subgroup
Any datixes relating to young person with self harm/suicidal ideation absconding from ward/ED	Kirsty Lewis (ward)/Sarah Blackburn (ED)	Reporting	Quarterly	CAMHS subgroup

10.0 References - Legal, professional or national guidelines:

- CP06 Consent Policy
- CP41 Children's Safeguarding Policy
- OP11 Mental Health Act Administration Policy
- OP53 Missing Patient Policy
- Self-Harm – The short-term physical & psychological management & secondary prevention of self-harm in primary & secondary care (NICE, 2004)
- The Mental Health Act (1983), (2007)
- The Children Act (1989), (2004)
- Working Together to Safeguard Children (2010)

- NICE Guideline No 16: Self-harm – The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care(July 2004).
- NICE Clinical Guideline 133: Self-harm: longer-term management (Nov 2011).
- College Report from the Royal College of Psychiatrists CR192: Managing self-harm in young people. (2014).
- College Report from the Royal College of Psychiatrists Cr158. Self-Harm, Suicide And Risk: Helping People Who Self-Harm (2010).
- Mental Health in Emergency Departments – A toolkit for improving care. October 2019 revised

Document Control

Policy number and Policy version: **CP63**	**Policy Title** Paediatric Self-Harm Policy (CAMHS and Acute Hospitals in Black Country)	**Status:** Final		**Author:** Consultant Paediatric Emergency Medicine **Chief Officer Sponsor:** Chief Medical Officer (Dr Brian McKaig)
Version / Amendment History	Version	Date	Author	Reason
	3.0	October 2022	Consultant Paediatric Emergency Medicine	Review

Intended Recipients: Staff responsible for the care or treatment of those aged under the age of 18 years.	
Consultation Group / Role Titles and Date: Mental Health Liaison Group, Black Country MH Foundation Trust CAMHS leads	
Name and date of Trust level group where reviewed	Mental Health Operational Oversight Group Trust Policy Group – October 2022
Name and date of final approval committee	Trust Management Committee – October 2022
Date of Policy issue	November 2022
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	October 2025 (review every 3 years).
Training and Dissemination: mandatory training form April 2022. Induction in areas where those under the age of 18 are assessed or treated.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes ~~/ No~~**	
To be read in conjunction with: CP06 consent policy, CP41 Children's safeguarding policy, OP53 Missing Patient policy, OP11 Mental Health Act Administration Policy.	
Initial Equality Impact Assessment (all policies): Completed Yes / No Full Equality Impact assessment (as required): Completed Yes / No / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	Quality Safety Advisory Committee (QSAC) report 6 monthly.

Document summary/key issues covered This policy assists clinicians and other clinical staff who provide care and treatment to children presenting to Emergency departments (ED), and walk-in centres and any in-patient facility in an acute hospital, following an act of self-harm, or where there are concerns about potential self-harm / risk to self/others or other mental health presentation. This policy is to apply across the Black Country (BCHFT) and pertains to all Children and young people up to the age of 18 years.	
Key words for intranet searching purposes	Mental Health CAMHS Self harm **CP63**
High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**~~Yes~~ / No (delete as appropriate)** If Yes include the following sentence and relevant information in the Intended Recipients section above – In the event that this is policy is made available to the public the following information should be redacted:

Part B **Ratification Assurance Statement**

Name of document:

Name of author: Job Title:

I, the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.

- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.

- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).

- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.

- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.

- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.

- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author:

Date:

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title:
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator

IMPLEMENTATION PLAN

To be completed when submitted to the appropriate committee for consideration/approval

Policy number and policy version	**Policy Title**	
Reviewing Group		**Date reviewed:**
Implementation lead: Print name and contact details		

Implementation Issue to be considered (add additional issues where necessary)	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form		
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed		
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?		
Financial cost implementation Consider Business case development		
Other specific Policy issues / actions as required **e.g. Risks of failure to implement, gaps or barriers to implementation**		

Appendix 1 Pathways for emergency care

Flow chart for Emergency Departments for Children & Young People presenting with mental health risk/crisis presentations.
Pathway 1

Patient Journey

Child, Young Person with Family/ Carers arrives in ED

Assessment

Admission to Paediatric wards will only occur for the following reasons
- Medical reason
- Parent/Carer not present

For all other situations to be assessed by CAMHS CIHTT:
- CYP
- Family/carer
- CYP and family/carer together

To receive a mental health assessment as soon as fit to assess i.e. if A&E staff assess as physically fit for interview.

Action by A&E staff

Details taken by reception staff and recorded

Triaged by the A&E nurse

Assessment by ED clinician:
- Medical history
- History of presenting issue
- Investigations (bloods if OD

If Self Harm. Request assessment in ED or refer to CAMHS crisis for telephone triage and divert to CAMHS

If Mental Health with no self-harm request a mental health assessment from CAMHS CIHTT ††

If intoxicated with alcohol/ Substances. Consider safeguarding and refer to DECCA or 360 if

In hours: (08.00 – 20.00) Inform CIHTT on
07900226390 Wolves
07816075218 Sandwell
01922 607400 Walsall

Action by CAMHS

CIHTT contact wards/ED for referral information

Record information of potential referral

Check with A&E and records re history and possible outcome of assessment

Once 'Fit to Assess': Telephone triage with referrer and family/carer and consider diverting to base or attend and identify a private space to undertake assessment

Complete telephone triage- divert to base same day or offer emergency slot next day/ discuss initial safety plan

If assessed as safe to return to the care of parents/ Carer. Discharge with follow

If YP assessed as requiring an inpatient admission contact consultant psychiatrist

Safeguarding

Information sharing is essential to safeguard the child/young person
Follow the Trust's safeguarding children process

If there is an immediate child protection concern - contact the Police or/and MASH (multi-agency safeguarding hub)Wolverhampton – 01902555392; Sandwell – 01215693100; Walsall - 0300 555 2866; Dudley - 0300 555 0050
Out of Hours contact Emergency duty team (EDT) Wolves-01902552999

Share information about any safeguarding risks for the child/young person by communicating with health partners, including social worker; complete a MARF for all Children/Young people presenting to the department with self-harm or overdose.

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Patient Journey

Assessed as needing admission

Triaged by CIHTT as safe to go home with follow up

Wait in A&E while the admission is arranged

Receive discharge information/ advice and follow up plan

Return home

Transfer to the ward

CYP and family cared for on Paediatric ward until either:

- Assessed as fit for discharge
- Transferred to mental health inpatient bed

Discharged with follow up/home support or transferred to CAMHS inpatient unit

Action by A&E staff

When required
Out of hours: Telephone support is available for CY&F via 24/7 mental health advice service 0800 0086516 (Freephone)
For A&E staff consultation & advice is available via Penn Hospital 01902 444141 for urgent /emergency situations

†† Mental health assessments can take place at CAMHS bases i.e. Gem centre/Lodge Rd/The Elms/Canalside. This is possible for those Young People who do not require medical treatment and where the risk is deemed to be low. In order for this to happen a clinical discussion needs to take place between A&E and CIHTT. This can happen if there is capacity, it is deemed appropriate AND the Young Person and their family /carer are in agreement to travel to a CAMHS base for assessment. This assurance is documented in the A&E notes with names of clinicians.

Action by CAMHS

If child/YP requires a MH inpatient bed

CIHTT completes NHSE/I referral (form 1)

CIHTT locate MH inpatient bed via Provider Collaborative/Darwin

* The CAMHS Crisis Intervention & Home Treatment Team (CIHTT) operates a 7 day service between 08:00 & 20.00. Given the length of time it takes to assess a Young Person the latest time a referral can be accepted is 18.00
This still should not automatically lead to an admission to the paediatric ward. Between 18:00-20:00 hours CIHTT can offer telephone triage which may avoid admission to paediatric ward or AMU as an urgent appointment the following day (at CAMHS base) can be offered following telephone triage and a safety plan for overnight can be discussed with CYP&F by CAMHS CIHTT.
** The decision on the appropriate place to assess the Young Person is based upon the criteria above.
Where the Young Person does not co-operate with the assessment, it is for the CAMHS clinician to determine the level of risk and whether admission is required.
It is also for the CAMHS clinician to determine the level of intent of an overdose which would not require admission for medical reasons.

Safeguarding

Remember

- Record clearly any safeguarding concerns
- Notify the safeguarding team

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Appendix 2 Inpatient care.

Patient Journey

Child, YP with Family/ Carers is admitted to Paediatric ward either after 20:00 hours as assessment in A&E not possible by CAMHS CIHTT OR due to medical treatment required or other risk indicator

Young person will be assessed by CAMHS CIHTT either alone, or in presence of carer/parent depending on wishes of CYP

Safety plan, follow up within 7 days and discharge agreed

Fit to be discharged from a MH perspective but awaiting social care input

Need to remain on ward due to MH need such as MHA assessment or referral to CAMHS inpatients or ongoing

YP will be supported and reviewed on the ward by CAMHS CIHHT. YP may have additional support in place such as a 1:1 nurse. YP parent carer will be involved in processes such as MHA assessment or CETR

Action by Paediatric team

Admission to ward. Ward team to consider any immediate risk issues and need for ligature light room or any special observations which may be required and manage any physical health needs such as NAC treatment, re-feeding bloods etc. or any other special considerations such as MHA

08:00-20:00 hours 7/7 - Ward team contact CIHTT to advise of YP's presentation and agree when medically fit to be assessed by CIHTT.
07900226390 Wolverhampton
07816075218 Sandwell
01922 607000 Walsall
013894 324689 Dudley

If between 20:00-08:00 if CAMHS advice/consultation required then ward team contact the on call CAMHS Consultant Child Psychiatrist via Penn hospital switchboard on **01902 444141.**

Outcome NAC or other treatment completed. Medically fit to be assessed by CIHTT

Ongoing medical need but MH review required due to co-morbid presentation such as anorexia, ward team refer to CIHTT

High risk and detention under MHA Section 5(2) implemented. Ward to liaise with CIHTT or OOH on call psychiatris

Action by CAMHS team

08:00-08:30 hrs daily CIHTT contact wards by telephone for referral information

Referral received after 08:30 but before 18:00

Record information regarding referral, check RIO and if known to LA. Agree time with ward team to attend and assess (KPI within 12 hours)

CIHTT complete MH assessment with CYP and with carer/parent. Agree safety plan, follow up and discharge.

CIHTT complete MH assessment but ongoing risk identified and not fit for discharge due to ongoing social care or mental health need or risks. Discuss with ward team. Liaise with social care. Consider discharge

If YP assessed as requiring an inpatient admission then CIHTT to complete all necessary steps regarding this. CIHTT to request a CETR if required. Completion of referral, liaison with NHSE and inpatient gatekeeping etc. CIHTT to assess if home treatment is possible and discharge to home treatment OR CYP to remain on ward with

CIHTT locate MH inpatient bed via Provider Collaborative/Darwin

Safeguarding

Information sharing is essential to safeguard the child/young person Follow the hospital's safeguarding children

If there is an immediate child protection concern - contact the Police or/and MASH (multi-agency safeguarding hub) Wolves-01902555392 Sandwell-01215693100
Walsall - 0300 555 2866;
Dudley - 0300 555 0050

Out of Hours contact Emergency duty team (EDT)
Wolves-01902552999
Sandwell 0121 569 2355
Walsall 0300 555 2922
Dudley - 0300 555 8574

Share information about any safeguarding risks for the child/young person by communicating with health partners, including social worker; check notes to see if A&E have completed a MARF. Update info via MASH or complete further MARF if required

Appendix 3

Emergency Department **Child (under 18) Mental Health Triage**

Date: D D / M M / Y Y Y Y Time of assessment: H H : M M

These guidelines are designed to help an assessor consider the risk to the patient of self-harm or suicide and risk of harm to staff members. Risk assessment requires clinical judgement which may override this form in some circumstances.

For staff use only
Hospital number:
Surname:
First names:
Date of birth
NHSno: _ _ _ / _ _ _ / _ _ _ _ :

Use hospital identification label

Does patient have a management plan? ☐Yes ☐ No

Issues to be explored through questioning

Why is the person presenting now?

Are there any events that precipitated this presentation?

Has the person self harmed? see page 2

Is the patient's family with them? If not, have they been contacted?

Physical description – include height, build, distinguishing features, clothing, skin colour, hair colour and style

Background, observations and behaviours

Please tick appropriate response	Yes	No
1. Does the person have any immediate plans to harm self or others or to damage property?	☐	☐
2. Is the patient obviously disturbed, threatening, agitated or unpredictable in their behaviour?	☐	☐
3. Is there any suggestion that the person may abscond?	☐	☐
4. Does the person have history of violence?	☐	☐
5. Does the person have a history of mental health problems or self harm?	☐	☐
6. Has the person been detained under a mental health section before?	☐	☐

Nursing assessment

Do you think this patient has the capacity to decide to leave?	☐Yes	☐No	☐Not sure
What level of risk do you think this patient has?	☐High	☐Medium	☐Low
Has this patient been searched for weapons or medicines?	☐Yes	☐No	
Observation level required	☐Red	☐Amber	☐None

Print name:
Signature:
Designation:

Date: D D / M M / Y Y Y Y
Time: H H : M M
Contact/Bleep number:

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The suicide risk screen is for use by doctors or nurses and may be an aid to risk assessment

Suicide risk screen

The greater the number of positive responses, the higher the risk

	Yes	No	Maybe		Yes	No	Maybe
Previous self-harm	☐	☐	☐	Family history of suicide	☐	☐	☐
Previous significant suicide attempt	☐	☐	☐	Poor school attendance	☐	☐	☐
Current suicidal thoughts	☐	☐	☐	History of being bullied / cyber bullying	☐	☐	☐
Current suicide plan	☐	☐	☐	Male	☐	☐	☐
Hopelessness/helplessness	☐	☐	☐	Lack of support or breakdown in social circumstances	☐	☐	☐
Low in mood	☐	☐	☐	Family concerned about risk	☐	☐	☐
Displaying bizarre or unpredictable behaviour	☐	☐	☐	Poor adherence to psychiatric treatment	☐	☐	☐
Alcohol/drug misuse	☐	☐	☐	Access to lethal means of harm	☐	☐	☐
Chronic pain or illness	☐	☐	☐		☐	☐	☐

Clinical assessment – *this must be completed by a doctor or ED staff before admission*

After full assessment, what level of risk do you think this patient has?	☐ High	☐ Medium	☐ Low
What level observations should continue?	☐ Red	☐ Amber	☐ None
Do you think this patient has capacity to decide to leave?	☐ Yes	☐ No	

Print name: Date: D D / M M / Y Y Y Y

Signature: Time: H H : M M

Designation: Contact/Bleep number:

Summary of levels of risk and suggested actions

Low	No special observations required
Medium	Consider 15 minute amber special observations If patient absconds inform the doctor in charge, security and police
High	Start red continuous special observations, inform department lead of patient's presence in ED If the patient absconds, inform the doctor in charge, security and the police

Actions to be taken according to level of risk identified

Risk level	Risk factors	Actions
Low	• There may be minor mental health issues but no plans to harm self or others • No evidence of immediate vulnerability	• Treatment and follow up to be arranged by ED team • Consider referral to primary care services eg. GP • May benefit from mental health advice and offer individual relevant advice booklets
Medium	• Person has ideas regarding risky behaviours towards self or others • Mental state likely to deteriorate without treatment • Patient is potentially vulnerable	• Implement immediate **Amber Special** and complete relevant specialising documentation • Inform department lead of the patient's presence in the Department/CDU and ask for assistance with staffing where necessary • Urgent referral to CAMHS Crisis • All attempts should made to stop the patient leaving the department before seeing a mental health professional • If the patient absconds, inform the doctor in charge, security and the police • Consider use of Section 5 (2) of MHA
High	• Serious mental health problems present, including	• Implement immediate **Red Special** and complete relevant specialising documentation

NHS number

Hospital number:

	possible psychosis • Patient has strong/immediate plans to harm self or others • May have already attempted to harm self or others • Mental health very likely to deteriorate if left untreated • Patient is highly vulnerable	• Nurse allocated specialising duties to wear alarm to summon immediate help if patient tries to abscond • Inform department lead of the patient's presence in the department/CDU and ask for assistance with staffing where necessary • All attempts should be made to stop the patient leaving the department • Consider the use of Section 5 (2) • If the patient absconds, inform department lead the doctor in charge, security and the police • Follow missing patients procedure

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Black Country Healthcare NHS Foundation Trust

CAMHS SINGLE POINT OF ACCESS - REFERRAL FORM

Dudley Referrals: camhsdudley.DWMH@nhs.net
Walsall Referrals: camhswalsall.dwmh@nhs.net
Sandwell Referrals: bchft.sandwellspa@nhs.net
Wolverhampton Referrals: BCHFT.WolvesCAMHSSPA@nhs.net

Please note - **ALL FIELDS ARE MANDATORY** unless otherwise specified and incomplete referral forms will be returned for your completion.

SECTION A – Child/Young Person's Referral Information

Full Name:		Date of Birth:		Gender: ☐ Male ☐ XFemale
Full Address: Postcode:		NHS Number:		
		Contact Number(s):		
Ethnicity:		School/College:		
Parent/Carer Name Contact Number(s): (if different):		Child/Young Person's GP Details:		

SECTION B – Referrer's Details

Name:		Service/Department:	
Full Address: Postcode:		Job Title/Profession:	
		Email Address:	
Contact Number(s):			

SECTION C – General Referral Information

Consent to referral

Is the child/young person aware of this CAMHS referral and is consent given? ☐ Yes ☐ No If no, details:
Is the parent/carer aware of this CAMHS referral and is consent given? ☐ Yes ☐ No If no, details:
Has the child/young person previously been referred to CAMHS? ☐ Yes ☐ No ☐ Do not know

Consent to share information

In the case that your referral is reviewed and it is determined that CAMHS is not the appropriate service, we are able to forward your referral to the service that we feel would best suit your needs. The services that we can forward your referral to may be within other NHS Trusts, Local Authority organisations or other 3rd party organisations such as charitable or voluntary sector services.
To enable us to ensure that you have access to the most appropriate service, we require your consent to allow us to forward your referral onto the alternative services. Can you please identify below if you are happy for us to forward your referral onto a third party.

I confirm that I am happy for you to forward my referral onto the following organisations if the services that they provide are more appropriate for my needs *(tick all that apply)*:

☐ Other NHS Services
☐ Local Authority Services
☐ Other 3rd Party Service providers

Print:
Sign:
Date:

Needs

Does the child/young person have a Learning Disability? ☐ Yes ☐ No If yes, severity:
Does the child/young person have any physical/mental health conditions? ☐ Yes ☐ No If yes, details: Depression
Is the child/young person currently prescribed any medication? ☐ Yes ☐ No If yes, affix summary:
Is an interpreter required for child/young person or parent/carer? ☐ Yes ☐ No If yes, details:
Will the parent/carer be able to understand the correspondence that we send? ☐ Yes ☐ No If no, details:
Are there any barriers that may prevent attendance at initial appointment? ☐ Yes ☐ No If yes, details:

Legal Status

Tick any of the following that apply to the child/young person and complete details (see full referral criteria for further details):

☐ Child or Young Person in Care* Details:
☐ Subject to a Child Protection Plan* Details:
☐ Subject to a Child in Need Plan* Details:
☐ Adopted* Details:

Black Country Healthcare NHS Foundation Trust

If a box above is ticked, please confirm that the Social Worker is aware of and supports the CAMHS referral? ☐ Yes

Social Worker Details (*must be completed if a box in the above section is ticked)	
Name:	
Address/Base:	
Contact Number(s):	

Professional Network

Please tick and name other professionals currently involved with the child/young person (or family if relevant):

☐ Paediatrician:
☐ Social Worker:
☐ Occupational Therapist:
☐ Health Visitor:
☐ Counsellor:
☐ Educational Psychologist:
☐ School Nurse:
☐ Speech & Language Therapist:
☐ Dietitian:
☐ Other:

SECTION D – Presenting Difficulty Referral Information

Please describe your reasons for referring the child/young person to Base 25/CAMHS (additional information can be attached)
Please outline any known risk issues (social, education or health) and state if these are current or historic: (In the event of self-harm and/or suicidal thinking, please provide as much information as possible) (In the event of any immediate safeguarding concerns, information will be shared with the appropriate agencies)

Do you consider this referral to be urgent? ☐ Yes ☐ No

If yes, please give clear reasons on the basis of the child/young person's mental health:

Please list any supporting information that accompanies this referral form:

Has this referral been verbally discussed with a member of the CAMHS SPA Team? ☐ Yes ☐ No If yes, date:

Note to referrers

- The quality of the information you provide will help us to process and prioritise this referral more effectively
- Where appropriate, we will signpost or refer young people onto alternative services, if this is not possible, you will be advised

Referrer's Signature (initial for electronic):	
Date:	

Appendix 5 – Guide to use of the Mental Health and Mental Capacity Acts for paediatric patients– see also OP11 Administration of the Mental Health Act Policy and CP06 Consent Policy

1) The Mental Health Act 1983, amended by the Mental Health Act 2007, can be used on any paediatric patient who has a mental disorder and who may be a risk to themselves or others. There is no lower age limit. Mental disorder is defined as: 'any disorder or disability of mind'. Risks to self may include suicide or deterioration in health. If there is a risk of significant harm to others, it may be more prudent to let the young person leave hospital, rather than prejudice the care of other young patients by trying to keep him or her on the children's ward.

2) A Mental Health Act section 5(2). This is a holding order for 72 hours. This is signed by the responsible consultant (paediatrician) and the duty administrator / manager. The necessary papers are usually kept in A & E or on any other identified area. The expectation is that a MHA assessment will be arranged before the 72 hours is over – or the 5(2) will be reviewed.

3) **A & E:** One way someone can be detained in A & E once they are there is by a section 2 (28-day assessment order), which requires a psychiatrist, a second doctor, an Approved Mental Health Practitioner and an inpatient bed (which can be paediatric if there are no adolescent psychiatric beds immediately available; beds on adult psychiatric wards should not in general be used for under-18s – see (5) below). This takes some time (usually over an hour) to set up – but it can be quicker if the young person freely consents to psychiatric admission. The young person can be kept in A & E under parental consent or common law in the meantime. If the young person tries to run away, the senior clinician present has to balance the young person's need for constraint against the risks of exercising constraint (to other patients and those doing the constraining). The majority of young people will however stay in one place if they are told they have to.

4) If a young person has run out of A & E, the police can be requested to bring them back, utilising the powers of **section 136** (police holding order) if there is reason to suspect a mental disorder (no diagnosis is necessary) *and* risk to self or others. The police are not allowed to do this for someone in their own home or in A & E. They may take them to the police station rather than back to A & E – for instance if the senior clinician present thinks the risks of waiting in A & E is too great. The police should then stay with the young person in A & E until a section 2 assessment has been completed, which should lead either to the young person being allowed to leave, or to being admitted (possibly to a children's ward).

5) If a young person agrees to come onto the children's or adult ward, and then changes their mind, they can be kept in against their will, using either:

   a) **Common law** (for limited periods of a few hours);

   b) **Parental consent** (for limited periods of a few days) – not recommended for those who are thought to be Gillick competent to refuse admission.

   c) **The Children Act (1989).** Those looking after a child or young person on a children's ward may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or

promoting the child's welfare' (section 3(5)). Whether the intervention is reasonable or not will depend upon the urgency and gravity of what is required and the extent to which it is practicable to consult a person with parental responsibility. For instance, if an 11-year-old is being treated on a children's ward, becomes distressed and attempts to leave, then he can be prevented from leaving by any member of staff involved in his care, if it is thought that he is vulnerable to harm beyond the safety of the hospital ward. The maximum period during which a child or young person's liberty may be restricted without either parental consent ((b) above) or a Mental Health Act order ((d) and (4) below) or the authority of a court (section 25 Children Act 1989) is 72 hours, either consecutively or in aggregate in any period of 28 days.

6) A young person can be kept on a children's ward under a **section 2**, if necessary with agency Registered Mental Health Nurses (requiring special funding from the commissioners). This should in general only be necessary until an appropriate adolescent psychiatric bed can be found. Residence for any length of time on the children's ward may be inadvisable if the young person presents a risk to other paediatric patients – despite the extra nursing. The Mental Health Act 2007 effectively makes admission of under-18s to adult psychiatric wards illegal – unless there is a professional consensus that this is the best option for the young person. This would usually be only if a young person is very nearly 18 years old, or in exceptional circumstances. The need to avoid admission of under-18s to an adult psychiatric ward puts pressure on commissioners to fund emergency adolescent psychiatric provision, on inpatient units to provide emergency access to beds, and on community CAMHS services to provide out-of-hours services to enable more young people to be managed in the community – but in the absence of any of these, on children's wards and staff!

7) **The Mental Capacity Act** (2005) applies to over-16s. It can be used to enable decisions to be made on behalf of a young person – usually by someone with parental responsibility, but sometimes by professionals. An over-16 can be considered unable to make a particular decision only if:

a) He or she has 'an impairment of, or disturbance in, the functioning of the mind or brain', whether permanent or temporary; AND
b) He or she is unable to undertake any of the following steps:
    i. Understand the information relevant to the decision;
    ii. Retain that information;
    iii. Use or weigh that information as part of the process of making the decision;
    iv. Communicate the decision made (whether by talking, sign language or other means).

Decision-making capacity is decision-specific and time-specific. When decisions are made on behalf of someone who lacks capacity, they must be made in his / her best interests. In practice, most such patients encountered by paediatricians will have learning difficulties, and should have carers who can make appropriate decisions for them. It should be noted that the Mental Capacity Act cannot be used if a deprivation of liberty is involved (such as keeping a child on a children's ward against their expressed wishes) – in which case another route must be taken.

8) The Code of Practice to the Mental Health Act (2007) introduces the concept of **The Zone of Parental Control.** This means what an adult can decide about a child under 16 or a young person of 16 or 17 for whom she

or he has parental responsibility. Medical procedures on children under 16 would normally fall within the zone of parental control, providing:

a) The decision is one that a parent would normally be expected to make. More extreme interventions are likely to fall outside the zone.
b) There are no indications that the parent might not act in the best interests of the child. If there could be a conflict of interest for the parent (as might occur after an acrimonious divorce), or if the child has alleged abuse by the parent, then professionals may decide to restrict the zone of parental control.
c) There is no reason to suppose the parent lacks the capacity to consent (for instance due to substance misuse or learning disability).
d) The young person agrees with the treatment proposed. If the young person is resisting, then more justification is needed to use parental consent alone.

Decisions regarding 16- and 17-year-olds are likely to fall within the zone of parental control only if the young person lacks the ability to consent for themselves (see previous section).

9) Recent changes in legislation, and its interpretation by case law, have had the effect of giving **more power to the child**: there are hoops to jump through to admit or treat a 16- or 17-year-old without their own consent; and the views of under-16's must be sought. A Gillick-competent under-16 should in general not be admitted or treated on parental consent alone.

10) The exception to this is in an **emergency**: if the failure to treat is likely to lead to the child or young person's death or to severe permanent injury the child or young person may be treated without any consent. Treatment under these circumstances is limited to what is necessary to save the child or young person's life or prevent an irreversible serious deterioration of their condition. Once the child or young person's condition is stabilised, the legal authority for providing any further treatment must be clarified.

11) **Legal advice** should be sought in any situation where the best way forward is unclear. The Trust legal team can be contacted via the exec on call. While waiting for this, you are unlikely to be criticised for choosing what appears – after discussion with colleagues – to be the safest option.

Appendix 6 CAMHS CIHTT referral form

CAMHS CIHTT
Sandwell, Wolverhampton, Dudley, Walsall
Telephone: Mon-Fri 8am-6pm 01216126687/6620 Sandwell;
01902444857/444021 Wolverhampton; Dudley 01834324689 Walsall 01922607400
Out of Hours Sandwell 07816075218 Wolverhampton 07900226390 Dudley & Walsall 01922 607000
All fields must be completed.

1. Referrer Details

Name of Referrer :	Designation:
Location:	Contact Number or Bleep Number:
Date:	Time of referral:

2. Client Details

Name of child:	D.O.B:
Address: Post Code:	Gender: **Female / Male** Ethnicity: Religion:
Telephone Number:	Interpreter Required: Y ☐ N ☐
NHS Number:	**If Yes what language:**
Oasis Number	

3. Parent/Carer Details

Name of Parent/Carer:	Address if different from above:
Telephone Number:	

4. School/GP Details:

School: Address: Post Code:	GP: Address: Post Code:

5. Additional Details

Is the young person accompanied by parent/carer: Y ☐ N ☐

If 'No' who accompanied the young person?

Is the young person aware of the CAMHS referral : Y ☐ N ☐

6. Clinical Details

Reason for referral:

Office use only	
Time Call Received:	Time of Triage:
Was Response to A&E/Ward within 2.5 hours? If No: Reason	
Was the Client admitted to the Ward? If No, where was the client admitted to?	
If Yes please tick reason: Mental Health Assessment ☐ Risk to Self or Others ☐ Medically Unfit ☐ Medically Unfit ☐ Mental Health Treatment ☐ Mental Health Act Assessment ☐ Needs Tier 4 Admission ☐ Safeguarding ☐ / Other (Please State)	
Length of stay in hospital	Which service was the client discharged to?

Appendix 7 Request for additional staffing for CAMHS patients on Paediatric wards to facilitate 1:1 observation when high risk has been identified.

Patient Name:	**DOB:**
Address:	**GP:**
NHS No:	**CCG:** **Wolverhampton CCG**
Rationale/Risk assessments/reason for 1:1 observations:	
Staffing required? HCA/RMN etc.	
For how long/how often will this be reviewed/by whom?	
Discussed with: **Agreed by:** **Contact details:**	