Practice Guidance and Care Pathway for Children and Young People who are admitted to Psychiatric In-patient Units in Essex

Updated October 2015

This guidance outlines expectations in relation to all children/young people, who are admitted to Psychiatric In-patient Units and emphasises the importance of planning for discharge. This practice guidance has been agreed by the North Essex Partnership University Foundation Trust (NEP), South Essex Partnership Trust (SEPT), North East London Foundation Trust (NELFT) and Essex County Council. The guidance is endorsed by NHS England, as commissioners of inpatient child and adolescent psychiatric care, as best practice in partnership working to ensure that the needs of the child/young person are met and there is good multi-agency discharge planning when the young person is becoming ready to leave hospital.

If children/young people need to be admitted to a Psychiatric In-Patient Unit within Essex, they will usually be admitted to one of the following Units:-

- St Aubyn Centre — Colchester (managed by NEP)
- Poplar — Rochford (managed by SEPT)
- Brookside South — Goodmayes (managed by NELFT)

However there are cases where young people are admitted to units across the country due to the way T4 CAMHS are currently commissioned.

Introduction

Whilst the numbers of children/young people admitted to Psychiatric In-Patient Units are relatively low, these are clearly very significant experiences in a child/young person's life. All agencies need to communicate and co-ordinate the planning and decision making for each child/young person in such situations. This is particularly important if the child/young person is receiving support from a Local Authority other than the one where the unit is located. If a child or young person admitted to a Psychiatric In-Patient Unit does not ordinarily live in Essex then the unit must make contact with children services in the local authority within which the young person is ordinarily resident. Any disputes or disagreements must be resolved using the dispute resolution procedures of the authority within which the young person is ordinarily resident.

Purpose

This guidance is intended to enable co-ordinated and appropriate support to be provided to all children who are admitted to In Patient Psychiatric Units and follows recommendations from Serious Case Reviews.

Information sharing

This guidance reflects the Information Sharing procedures within the Southend, Essex & Thurrock (SET) Safeguarding Children guidance which all agencies have signed up to.

1. Admission to Psychiatric In-Patient Units

1.1 On admission, the legal status of the child/young person, the identity of who has parental responsibility and the nature of their involvement with the child/young person must be clarified and recorded in the clinical record. It is essential to identify any 'absent' parents and to consider their involvement and whether the child/young person is known to Children's Social Care.

1.2 If the young person is already receiving a service from Children Social Care they will be supported as either a Child in Need, a child who is the subject of a Child Protection Plan or a Looked After Child. The process for each situation is set out under section 3

1.3 An initial formulation meeting should be held within ten working days of the child/ young person's admission. Where it is anticipated that discharge may occur earlier, the formulation / discharge planning meeting may be combined and held earlier and involve the young person's keyworker in the inpatient unit and chaired by a member of the multi-disciplinary team. The Care Programme Approach (CPA) Coordinator must attend.

Where social care are involved then the named/allocated Social Worker must attend all CPA meetings/reviews including the formulation meeting and are expected to be involved with the Clinical Psychiatric Team in joint decision making. Times of CPA meetings should be negotiated with invitees. Units should ensure Quadrant Service managers and team managers are

advised of routine times for ward reviews.

1.4 The child/young person should have access to independent advocacy. Where a young person has an existing advocate; this advocate should be invited to attend CPA Reviews and to continue to support the young person. Where a young person does not have an existing advocate:

- The named/allocated Social Worker and the CPA Co-ordinator should ensure advocacy is available
- Post-discharge, advocacy to be addressed by named/allocated Social Worker or the Independent Reviewing Officer if there is one

1.5 For incidents involving allegations against staff or other service users consideration must be given to informing children's social care and advice from the Trust's Head of Safeguarding should be sought.

1.6 Planning for discharge for all young people must commence on day 1 of admission. The CPA Discharge Planning Meeting must be held before the child/young person is discharged. The purpose of the meeting is to ensure that there is an appropriate multi-agency plan in place for the child/young person's discharge. (See section 4.)

2. Children who are not open to Social Care on admission

2.1 Any child/young person admitted to an adolescent inpatient unit should be considered to be a Child in Need. They/their parents have the right to request a Child in Need (CiN) assessment under the Children Act 1989.

There must always be a discussion with the young person and their family in relation to their agreement for making a referral to children's social care.

The Unit should seek valid informed consent, to notify Social Care of the admission and to request a child in need assessment.

Consent to share information should be sought from the child/young person or, where the child does not have capacity, an individual holding Parental Responsibility on day 1 of admission.

A referral to Social Care should always be made if:

a) parent's or competent young person agree to the information about them being shared with Social Care or;

b) there are grounds for making a referral due to concerns that the child or young person is at risk of significant harm.

There may be cases where the young person and his/her parents have different views about a referral to Social Care, and this needs to be

determined based on the individual circumstances and the factors referred to above.

Where parents or young person objects to a referral being made to Social Care and there are identified concerns about significant harm, a referral must proceed in the best interests of the young person as reflected in the Southend Essex Thurrock Guidance 2014.

Local Authority/Children's social care	**Contact Details**
Essex - Family Operations Hub	FOH@essex.gcsx..gov.uk tel: 0345 6037627 Out of hours 0345 606 1212
Southend	01702 215007 Out of hours 0345 606 1212
Thurrock	01375 652802 Out of Hours 01375 372468

2.2 On receipt of notification of admission, Social Care will consider whether to undertake a Child in Need assessment and will attend CPA reviews and discharge planning meetings as appropriate. Where Social Care decline to undertake an assessment a written explanation must be given.

3. Children who are open to Social Care on admission

Children in Need

3.1 Consent should still be sought from the young person and / or their parents in order to notify Social Care and make their allocated worker aware of their admission.

On receipt of notification of admission, Social Care will review the existing Child in Need plan. Social Care will attend CPA reviews and discharge planning meetings as appropriate for young people on the unit.

Children who are subject of a Child Protection Plan

3.2 If a child subject to a Child Protection Plan is admitted, Social Care is to be advised with or without the consent of the young person and parent. The Social Worker will advise the Child Protection Conference Chair, who, along with the Core Group will consider whether a review/emergency Child Protection Conference should be convened. There is an expectation that the potential risks and likelihood of significant harm will be re-assessed in light of

the young person's admission to the unit. The allocated Social Worker will update the Core Group on a weekly basis about the child/young person's progress and the planning. During this time the CPA or Key Worker should become a member of the Core Group.

3.3 For children subject to a Child Protection Plan the Core Group should update the Child Protection Plan, in consultation with the young person, parents and Chair, to reflect the needs of the child during and post admission.

The Child Protection Plan is to be made available to the CPA/Key Worker.

The CPA or Key Worker should attend a Review Child Protection Case Conference if required, and provide a report as per the Child Protection process.

The Social Worker will advise the School Nurse and other relevant professionals of the child/young person's admission

Looked After Children (LAC)

A child or young person is "Looked After" under the Children Act, 1989 if he/she is accommodated by the local authority:

- Under a voluntary agreement with parental consent or own consent if aged 16 or 17 (Section 20).
- Subject to a care order imposed by the courts (Section 38 or 31).
- Subject to an Emergency Protection Order.
- Is remanded to local authority care

3.4 Where a child is Looked After, the Designated Nurse Looked-After-Children (LAC) of the CCG in which the unit is situated, must be informed of the child/young person's admission by the young person's key worker within the respective psychiatric unit. The LAC Designated Nurse will liaise with the relevant LAC Designated Nurse where the child/young person originates from to identify the most appropriate Lead Professional (LAC) to be involved whilst the young person is an in-patient.

3.5 An overall CPA and Care Plan should be agreed at the CPA meeting. Where the young person is a LAC, the LAC Designated Nurse should be kept informed throughout a young person's admission and provided with minutes of Formulation Meetings and CPA Reviews.

3.6 Minutes and copies of reports discussed in CPA meetings will be shared with the allocated Social Worker and the LAC lead professional. In the event that the allocated Social Worker and LAC lead professional are unable to attend,

minutes of the meeting and reports will be electronically emailed to secure (gcsx / nhs.net) email addresses as required.

3.7 On-going responsibility for the child/young person's health care remains with the originating CCG to coordinate as required (as per admission form *Appendix 1)*

3.8 For LAC children, the named/allocated Social Worker must ensure that the Social Care Quadrant Director of Local Delivery (or appropriate equivalent), the Children in Care Service Manager and the child/young person's Independent Reviewing Officer (IRO) are made aware of the child/young person's admission within 24 hours.

The IRO should always consider whether it is appropriate to convene a statutory review within 8 days of admission. They should record the reasons if a statutory review is not required. In many cases the formulation and CPA meetings will provide a sufficiently comprehensive plan.

3.9 If the young person is voluntarily accommodated under section 20 of the Children Act 1989, the child/young person's parents or carers should be involved in formulation or discharge meetings or CPA reviews.

If the young person is the subject of an interim or full Care Order then the involvement of their parents in formulation or discharge meetings or CPA reviews will be at the discretion of the social worker and team manager.

3.10 For LAC children, planning for discharge must commence from day 1 of admission. Including immediate exploration of any additional support required within the community / placement.

3.11 The Independent Reviewing Officer should have access to the CPA Plan via the named/allocated Social Worker throughout the child/young person's admission and should ensure that both the child/young person's mental health and other assessed needs are being addressed.

The Independent Reviewing Officer or their manager is expected to attend the Pre-Discharge Meeting.

4. Discharge-planning

4.1 Planning for discharge for all young people must commence on day 1 of admission. The CPA Discharge Planning Meeting must be held before the

child/young person is discharged. The purpose of the meeting is to ensure that there is an appropriate multi-agency plan in place for the child/young person's discharge.

4.2 The CPA Discharge Planning Meeting will be arranged by a member of the Multi-disciplinary team in the inpatient Unit in conjunction with the CPA Co-ordinator. Five days' prior notice of the time/date/venue of the CPA Discharge Meeting must be given to all professionals including those not physically based on the psychiatric unit (including, if they are involved, the named/allocated Social Worker, the Social Care Access to Resources Team Manager, the SW Team Manager, the Lead Health Professional and the Independent Reviewing Officer).

4.3 The meeting will be chaired by the Consultant Psychiatrist. Where the Consultant Psychiatrist does not chair the meeting, they must formally delegate authority to a member of the multi-disciplinary team in the inpatient unit.

4.4 If it is considered by the child/young person, their parents, the CPA Co-ordinator, the Clinical Team, the Social Worker/Team Manager, or the Independent Reviewing Officer that the Discharge Plans do not meet the child/young person's identified needs then this concern MUST IMMEDIATELY BE ESCALATED to Service Manager level within SEPT/NEP/NELFT and the relevant Local Authority Social Care. The respective NHS Provider Trust lead for Safeguarding must be additionally notified by the young person's CPA Coordinator.

4.5 Every effort should be made to avoid the discharge of a Young Person from a psychiatric inpatient unit on a Friday. Where this cannot be avoided, appropriate support must be in place over the weekend.

Children in Need and Children subject to Child Protection Plans

4.6 Discharge planning meetings must take into account the views and wishes of the child/young person and the meeting must always consider potential risk and protective factors.

4.7 The meeting should be attended by the young person, their advocate, the CPA Co-ordinator, ward staff (and the Key Worker), the Consultant Psychiatrist and the named/allocated Social Worker.

Consideration should also be given to the appropriateness of inviting other key people including parents and family members (where appropriate), the child/young person's carers/future placement, the Social Worker's Team

Manager, (for Essex young people) the Social Care Access to Resources Team Manager, the Lead LAC Professional and the IRO.

Looked After Children

4.8 The Social Worker, Team Manager, Independent Reviewing Officer and LAC Lead Professional must attend and provide reports to the meeting to ensure the most appropriate discharge arrangements and plans can be developed and agreed.

If the Independent Reviewing Officer does not attend the Discharge Planning Meeting, the named/allocated Social Worker must ensure that the IRO has a copy of the Discharge Plan, including the rationale of the Plan, the monitoring, support and treatment plans, etc. The IRO must consider all the Plans that are in place, ensuring that all the child/young person's needs are to be addressed alongside the assessed mental health needs.

4.9 If the Social Care Team Manager is unable to attend the Discharge Planning Meeting the Service Manager must attend.

4.10 It is not considered appropriate to combine the CPA Pre-Discharge Meeting with the Statutory Child Looked After Review.

The Independent Reviewing Officer is expected to review the Discharge Plans and agree the appropriateness of the Plans.

Avoiding Delayed Discharge

4.11 Continued in-patient care for a child/young person who is clinically fit for discharge is never in the child/young person's best interest.

It is the named/allocated Social Worker and their Team Manager's responsibility to have identified, in advance, an appropriate placement for the child/young person to be discharged to and arrangements made to meet any additional needs.

4.12 An Interim Placement for the child/young person post discharge is to be avoided wherever possible. If this is necessary, it is very important that there are satisfactory handovers of the CPA and Care Plans to the interim placement and that there is on-going specialist support available to the child/young person and the carers/placement throughout the interim placement.

4.13 The young person's agreement, or objection, to Care Plans should be specifically recorded.

5. Discharge of the child/young person

Children in Need and Children subject to Child Protection Plan

5.1 At the point of discharge, there should be a clear and coherent CPA Plan. This should include follow up arrangements, the supports available to the child/young person and carers, any specific care issues, contact arrangements and the date/time of the Child in Need review meeting.

Looked After Children

At the point of discharge, there should be a clear and coherent CPA Plan. This should include follow up arrangements, the supports available to the child/young person and carers, any specific care issues, contact arrangements and the date/time of the Statutory Child Looked After Review. The CPA Plan should be consistent and integrated with the child/young person's Physical Health Care Plan.

5.2 For all children the Discharge CPA Plan must be shared with all appropriate professionals – e.g. the CPA Co-ordinator, the CYPS Clinical Team, the named/allocated Social Worker, the Social Work Team Manager, the Independent Reviewing Officer the LAC Lead Professional, the relevant LAC Designated Nurse, the child/young person's GP

Responsibility for sharing the Discharge CPA Plan lies with the CPA Coordinator.

5.3 The discharge plan should be incorporated into the child's psychiatric clinical record and shared with the community team who will provide post-discharge care.

The social worker should ensure that the discharge plan is incorporated into the child's social care record and shared with the IRO.

5.4 **Discharge during Home Leave**

Where a young person refuses to return to a unit from home leave and discharge is agreed, then the Key Worker must immediately inform the CPA Co-ordinator, the named/ allocated Social Worker and where appropriate, the LAC Lead Professional. If discharge of this child/young person is then being considered in their absence, a CPA Discharge Planning Meeting should be

convened as soon as possible and always within five working days. This Discharge Meeting must consider the assessment of risks involved (to the child/young person and to others), what further actions may be necessary, discharge and follow up arrangements.

Post Discharge:

Children in Need

5.5 For Children in Need consideration should be given to convening a Child in Need review meeting in order to ensure the best arrangements and support are available to the young person and their family following discharge.

Children subject to Child Protection Plans

5.6 Consideration must be given to holding a core group meeting or bringing forward the Child Protection Case Conference if there is a need to amend the Child Protection plan.

Looked After Children

5.7 Where a child/young person is a LAC, the child/young person's statutory "Child Looked After" review **MUST** take place within eight working days of the child/young person's discharge from the In-Patient Unit; this will be chaired by the Independent Reviewing Officer and the Social Worker/Team Manager, LAC Lead Professional and CPA Co-ordinator must attend the Child Looked After review.

Appendix 1:

Notification of Admission Procedural Guidance for children and young people admitted to inpatient psychiatric units.

When a child or young person (0-18) who is known to be “looked after” or subject to a Child Protection Plan is admitted to an in-patient Psychiatric unit it is imperative that the Designated Nurse for Looked after Children is alerted.

It is the responsibility of the staff member admitting the child to the unit to ensure the attached pro-forma is fully completed where possible to enable effective co-ordination once received.

Once completed this should be left with the Medical Secretaries who, within 1 working day of admission, will send the completed pro-forma via a secure email address (nhs.net account) to the identified secure email address:

Units to insert secure email address and telephone number for local Designated nurse LAC/Safeguarding team.

When sending the email a read receipt should be requested; this will act as confirmation that notification has been received. Confirmation of receipt will be no more than 2 working days of the initial notification being sent.

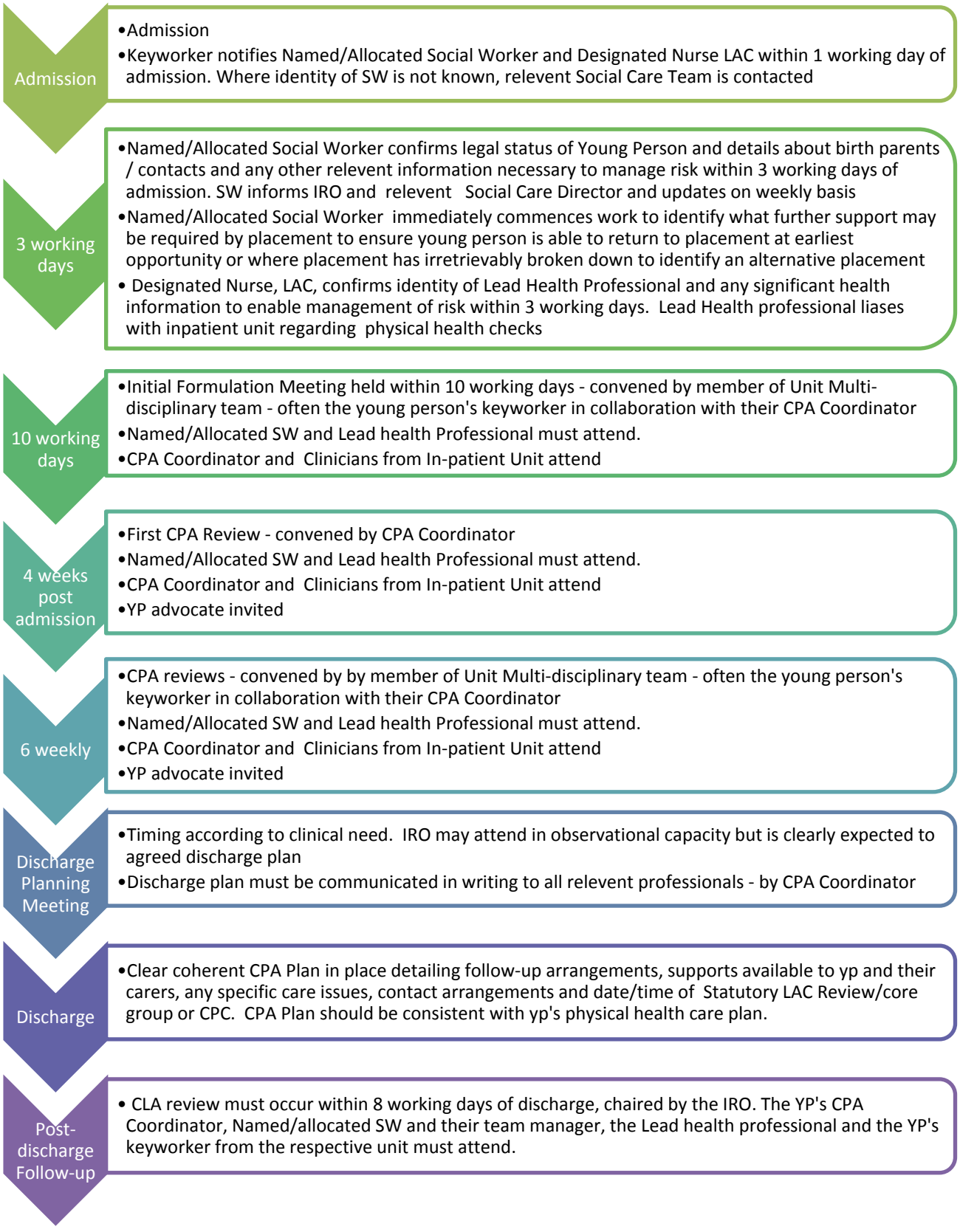
The role of the Designated Nurse does not replace the communication between staff caring for the child or young person and other agencies involved in the care plan such as the Child’s Social Worker. It is a supportive measure to ensure that the health needs of the child or young person are fully reflected on admission through to discharge and in accordance with statutory guidance. The role of the Designated Nurse is to liaise with other professionals or agencies to ensure care needs are met by those responsible

Admission Information for LAC Children admitted to inpatient psychiatric units

Childs Name and Date of Birth	
NHS Number	
Placement Address or where living at time of admission	
Home or originating address if different to above	
Name and contact details of person with parental responsibility for child or main carer.	
Legal status of child (if known)	
Name and contact details of allocated Social Worker	
Responsible local authority	
Details of GP: name , address and contact number	
School (if in education)	
Reason for and date of admission inclusive of route (voluntary/detained)	

Ward/Keyworker	
Date of last health assessment (if known)	

Appendix 2: Flow Chart of Care Pathway for LAC young people admitted to an inpatient psychiatric unit.



Appendix 3: Glossary of Terms

This glossary is intended for use only as a brief summary of terms referred to within the document.

Assessment On Admission *--- This is conducted by a nursing staff member and a Psychiatrist (which can be an on call duty Psychiatrist). Nursing team completes a mini-social history and provisional risk assessment on arrival and a Psychiatrist then does a medical evaluation as soon as possible but most likely within 24 hours.* ***Discharge planning occurs from the moment the young person is admitted onto the unit.***

Cafcass - Children and Family Court Advisory and Support Service *– is a Social work service independent of the courts, social services, education and health authorities and all similar agencies. Cafcass operates within the law set by Parliament and under the rules and directions of the family courts. Its role is to:*

- *safeguard and promote the welfare of children*
- *give advice to the family courts*
- *make provision for children to be represented*
- *provide information, advice and support to children and their families*

Care Programme Approach (CPA) Meetings*—These are conducted 4 weeks after the formulation meeting and 6 weeks there-after for as long as the young person remains on the unit. The meeting is attended by representatives from all members of the MDT team. The client's progress in all areas is discussed and reviewed and recommendations are made by all parties involved regarding the young person's care. External professionals are invited to attend including education professionals, CAMHS professionals, external psychiatrists, the General Practitioner, the Youth Offending Team, any pertinent community partners, and CAMHS crisis outreach team if they have an on-going role. Most importantly, the young person and their parents/caretakers attend. The young person sees an advocate and goes over their CPA documents prior to the meeting and their views are solicited, including making sure that they agree on the contents of the CPA document. Discharge plans are always being considered during this meeting to insure that we are working towards mainstreaming the young person back out into the community as soon as possible. Social care is invited to attend all meetings if the child is receiving support from a social worker.*

Care Order (preceded by Interim Care Order [S38]) Section 31, Children Act (1989)

The child is Looked After by the local authority by the order of a court. Parental responsibility is shared between the birth parent and the local authority.

Children Act 1989

This is the primary legislation that sets out the statutory duties and responsibilities in order to safeguard and promote the wellbeing of children. It defines a child as any person who has not attained their 18th birthday.

Section 85 of the Children Act 1989 requires Health or Education Authorities to notify Children's Services Specialist Services where they either have

accommodated a child for more than three months, or at the time they first accommodate the child, intend to do so for more than three months.

Section 86 of the Children Act requires anyone providing accommodation for a child in a residential care home or nursing home for more than three months, or intend at the outset to accommodate them for more than three months, to similarly notify Children's Services.

Child Protection Case Conference (CPCC)

A Child Protection Case conference will hear information about the family and about concerns that have been expressed, discuss whether or not the child is at risk of significant harm and whether there should be a 'child protection plan'. If it is decided that there is a need for a child protection plan, the child's name will be placed on the child protection register - also called the "at risk" register.

Child Protection Plan (CPP)

A child protection plan:

- *Assesses the likelihood of the child suffering harm and look at ways that the child can be protected*
- *Decides upon short and long term aims to reduce the likelihood of harm to the child and to protect the child's welfare*
- *Clarifies people's responsibilities and actions to be taken*
- *Outlines ways of monitoring and evaluating progress.*

Core Group

The core group is responsible for formulation and implementation of the detailed child protection plan, previously outlined at the child protection conference. Core group membership will have been identified at the child protection conference and includes the lead social worker, parents / carers, child (if appropriate) and other relevant family members.

Discharge Planning Meeting (Conducted as a CPA)--- O*nce the provisional discharge date is confirmed, discharge is more actively discussed during this meeting and plans are made to identify a date to discharge the young person back out into the community. This Meeting is attended by everyone involved in the child's life, by the young person and their parents/caretakers. CAMHS Crisis team attends if they have a role to play in supporting the young person's discharge by providing short term community support. The timing happens according to the clinical need of the young person. The social worker is also invited to attend if the child is overseen by Social Care.*

Discharge CPA*--- This meeting is conducted most likely the day the young person is planned to discharge from the Unit. All internal professionals are represented and all external professionals necessary for the child to be discharged successfully*

are invited to attend, including Education, CAMHS, CAMHS Crisis Outreach team, the GP, lead health professional, the external Psychiatrist, the early intervention and eating disorders teams (if clinically indicated), and representatives from social care. At this meeting, plans for discharge are finalized including the frequency and type of community support provided, plans for the young person's educational provision, and plans for the crisis team to provide 6-8 weeks of community support. Plans for follow up care with CAMHS, the GP and the external Psychiatrist are put in motion and if the child is on medication, they are given prescriptions to last them until they can be seen by their community CAMHS Psychiatrist and/or General Practitioner. Any medical issues are discussed which may need to be followed up on by the GP.

***Designated Doctor and Nurse** – strategic role to assist health bodies and social care in fulfilling their responsibilities as corporate parent for the child or young person. Provides expert advice and support to all health service providers (including child and adolescent mental health services, primary and secondary care providers), local authorities and any health body providing care for a child who is Looked After or subject to a child protection plan.*

Duty to Investigate, Section 47, Children Act (1989)

The local authority has a statutory duty to make enquiries when it has reasonable cause that a child is suffering or likely to suffer significant harm. Section 47 therefore empowers local authorities to call upon other professionals and agencies to assist them. When carrying out s47 enquiries the local authority has a statutory duty to obtain access to the child and therefore this duty is not subject to permission by those with parental responsibility.

Emergency Protection Order (EPO) Section 44, Children Act (1989)

This order lasts for a maximum of eight days and can be extended by up to seven days. The local authority can apply to the court when there is a belief the child is suffering or likely to suffer significant harm if the child is not removed from where they are or kept in a particular place (e.g. hospital).Whoever is granted the EPO (e.g. Social care) acquires temporary parental responsibility. In an emergency, immediate protection can be obtained by the police.

***Formulation Meeting**--- This meeting is held within two weeks of admission or as soon as can be scheduled. This meeting is led by a member of the MDT team and it brings together various, more thorough assessments and recommendations that have been done during the previous two weeks (i.e.: Educational assessment, Psychological assessment, Psychiatric assessment, Social Work assessment, Family Therapy assessment, Occupational Therapy assessment, Psychoanalyst assessment, and nursing assessment.) All formulations are considered and combined into a package of care which is then offered within the unit, including deciding upon the permanent care pathway that the young person will be on for the duration of their treatment. Most importantly, the young person and their family/ carers are a part of this meeting. The meeting can end up becoming the discharge*

CPA meeting if it appears that the young person is ready to be discharged and the parents agree with the recommendation for discharge.

***GP** – Lead Primary Care professional who holds the main health record for a patient.*

***Independent Reviewing Officer (IRO) –** The appointment of an independent reviewing officer (IRO) is a legal requirement under Section 118 of the Adoption and Children Act 2002. They are social work professionals employed or engaged by the local authority. They are distinct from the allocated Social Worker and have a statutory responsibility to quality assure and oversee care planning for children in care and ensuring that the child's views and wishes are being paid due regard. This includes chairing the statutory reviews for children in care and ensuring that the Care Plan is effective in meeting the needs of the child and safeguarding and promoting the child's welfare. The IRO must be kept informed of any significant changes to the Care Plan and significant incidents and events affecting the child, including placement moves. If the IRO is concerned about any aspect of the Care Plan or its implementation they have a duty to raise those concerns with the responsible Social Worker and Manager and escalate those concerns to Senior Managers and ultimately to Cafcass (see below) if those concerns are not addressed.*

***Lead health professional** – The key community child health professional for a child, usually the school nurse or health visitor. For a looked after child this includes undertaking health assessments, co-ordinating and monitoring health care plans and acting as key health contact for social workers and carers.*

Legal Aid, Sentencing and Punishment of Offenders Act, 2012

This is new legislation that became effective on April 1st 2013. It requires that any child who is accused of committing a criminal offence and placed on remand in a Young Offenders Institute or secure accommodation will be classed as a Looked After Child under section 20, Children Act, (1989) and benefit from the same support and services as any other child in care. This does not include the requirement for statutory health assessments to be undertaken if the child was not looked after prior to being remanded.

***Mental Health Act 1983:** Section 2 of the Mental Health Act 1983 allows for a patient (child or adult) to have their mental health needs compulsorily assessed as an in-patient for up to 28 days. Section 3 provides for the person to compulsorily receive treatment as an in-patient for up to six months. S.3 can be renewed for a further period of 6 months and then renewed for periods of one year therefore. Section 4 of the Mental Health Act 1983 is an emergency order that lasts up to 72 hours. It is implemented by just one doctor and an Approved Mental Health Practitioner, in an emergency in which there is not time to summon a second suitable doctor in order to implement a Section 2 assessment order or Section 3 treatment order. Once in hospital, a further medical recommendation from a second*

doctor would convert the order from a Section 4 emergency order to a Section 2 assessment order. Section 4 emergency orders are not commonly used.

Any Looked After Child admitted voluntarily or under either section of the Act should have their care plan reviewed by an Independent Reviewing Officer. If the child is Looked After under S20 CA89 and admitted under section 3 MHA83 their status as a Looked After Child ends and they become a child in Need (s17 CA89). Children who are subject to care orders (i.e. s31 CA89) remain Looked After regardless of whether they are admitted voluntarily or compulsorily.

***MDT (Multi-disciplinary Team)** - refers to all professionals on the unit (i.e.: Nursing, Psychology, Psychiatry, Social Work, Education, Occupational Therapist, Family Therapist, and Psychoanalyst).*

***MDT Assessment**--- This is conducted after admission within 3 working days by two clinical members of the MDT team and most likely a member of the crisis team, particularly if the crisis team member has been working with the young person. A Psychiatrist may or may not be present for an MDT assessment. If the Psychiatrist is not present, s/he is consulted with on pertinent issues related to the client's mental status, risk assessment, medical issues, etc. An education staff person is generally present, as well. During this assessment, a more thorough social history, risk assessment, educational assessment, safeguarding assessment and developmental assessment is conducted. External professionals are invited to observe or actively participate during the assessment and to provide recommendations. A provisional care pathway is also discussed and decided upon.*

***Named Nurse (Safeguarding or Looked After Children)** – Specialist nurse within children's community services who provides specialist advice, guidance and supervision to staff working within community services on child safeguarding. Specialist Nurses for Looked after Children lead community health services for Looked After Children placed in that area and for those whose health care is hosted by another provider. Co-ordinates service delivery and liaise between social care teams and other provider organisations to ensure delivery of care within universal services.*

***Nearest Relative** - A Nearest Relative is a relative of a mentally disordered person. There is a strict hierarchy of types of relationship that needs to be followed in order to determine a particular person's Nearest Relative: husband, wife, or civil partner; son or daughter; father or mother; brother or sister; grandparent; grandchild; uncle or aunt; nephew or niece; lastly, an unrelated person who resides with the mentally disordered person. Thus a person's Nearest Relative under the Act is not necessarily their "next of kin".*

A mentally disordered person is not usually able to choose their Nearest Relative but under some circumstances they can apply to a County Court to have a Nearest Relative replaced. In practice, such applications are more commonly made by Social Services Departments. The Nearest Relative has the power to discharge the mentally disordered person from some sections of the Act.

***NELPT** – North East London Partnership Trust*

***NEP** – North Essex Partnership University Foundation Trust*

Placement Order, Adoption & Children Act, (2002)

The long term plan for the child is adoption. Parental responsibility is shared between the local authority and the birth parents when the child is with foster carers. Prospective adoptive parents may consent to most healthcare interventions. Prospective adoptive parents would be considered a 'significant other' if an application was made for detention to hospital – Local Authority would identified as the Nearest Relative under s.27 of the MHA for the purposes of the AMHP fulfilling their duty to 'inform' (s.2) or 'consult' (s.3) the NR.

Police Protection Section 46, Children Act (1989)

A police officer can remove a child/or prevent the removal of a child (e.g. from hospital) for up to 72 hours if they believe the child is suffering or likely to suffer significant harm if action were not taken. This enables time, if appropriate, for an EPO to be obtained. This is only used in exceptional circumstances.

***Pre-admission Assessment**— This is conducted by two members of the MDT team, along with a member of the crisis team, to determine if inpatient admission is warranted or if young person can be maintained in the community with additional community and crisis outreach team support. If no admission is deemed appropriate, a community care plan is discussed amongst professionals and decided upon to be undertaken by the CPA Coordinator in conjunction with relevant professionals who have been working with the young person. If an inpatient admission is decided upon, the below stated assessments take place. A comprehensive CPA assessment should have been done in the community prior to this assessment being undertaken to underpin the relevant concerns to be more fully assessed for the purpose of deciding on whether or not an inpatient admission is warranted.*

Remanded to local authority care Section 21, Children Act, (1989)

Children who are on remand whilst criminal investigations take place may be placed in local authority care instead of being placed in a Young Offenders Institution.

Responsible Clinician

Responsible clinician" is defined in s34 (MHA, 2007) as:

(a) in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case;

(b) In relation to a patient subject to guardianship, the approved clinician authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the responsible clinician

"Approved clinician" is defined in s145 as:

... a person approved by the Secretary of State (in relation to England) or by the Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of this Act

In contrast with a Responsible Medical Officer, an RC does not need to be a doctor. However, sometimes a doctor is still required, for example the recommendations for initial detention under section 2 or 3 must be made by a registered medical practitioner.

Section 20, Children Act (1989)

Child is Looked After by the local authority with the parent's consent, or with the young person's own consent if aged 16 or 17 years. Birth parent retains parental responsibility.

Secure Order Section 25, Children Act, (1989)

The child is placed in secure accommodation for their own safety or the safety of others.

SEPT *– South Essex University Foundation Trust*

Weekly Ward Reviews*--- At the St Aubyn Centre, these take place on Wednesday morning for Longview and Thursday morning for Larkwood. Members of the nursing, education and MDT team come together with the Psychiatrist to discuss the client's weekly progress on the ward and to discuss alterations to the client's care on the ward. The young person's views are solicited in written and verbal formats, and decisions are made about home leave, family visits, observation levels, whether or not to alter the care plan, etc. This meeting is only for internal staff, although our Suffolk professional partners, the eating disorders team and the early intervention team participate, as does the trust safeguarding team at times.*