Livewell Southwest

Complex CAMHS – Operational Policy

Version No 1.2
Review: June 2017

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The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Asset Number: **866**

Reader Information

Title	Complex CAMHS Operational Policy. V.1.2
Asset number	866
Rights of access	Public
Type of paper	Policy
Category	Clinical
Subject	Operational Policy
Document purpose/ description	Operational policy describing the function of Plymouth Complex CAMHS team.
Author	CAMHS Senior Management Team
Ratification date and group	16th July 2014. Policy Ratification Group
Publication date	29th June 2016
Review date and frequency of review	29th June 2017 Three years after publication, or earlier if there is a change in evidence.
Disposal date	The Policy Ratification Group will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule, all copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Senior Management Team - CAMHS
Target audience	All Livewell Southwest staff
Circulation list	Electronic: Livewell Southwest (LSW) intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☎ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	Locality Manager for North West, Senior Management Team, Clinical Team Managers, CAMHS Clinicians.
Equality analysis checklist completed	Yes
References/sources of information	**N/A**
Associated documentation	**Healthy lives, brighter futures – the strategy for children and young people's health.** (Department for Children, Schools and Families and Department of Health: 2009): presents the government's vision for children and young people's health and wellbeing. **Children and young people in mind: the final report of the National CAMHS Review** (Department for Children, Schools and Families: 2008): provides an analysis of how children's health, education and social care services are contributing to the mental health and psychological wellbeing of children and young people. Identifies key challenges to

	sustainable improvements in the mental health and emotional wellbeing of children and young people. **Children's Plan: Building Brighter Futures** (Department for Children, Schools and Families 2007): the Government ten-year vision for children's and young people's health, building on the National Service Framework for Children, Young People and Maternity services, in that children's emotional wellbeing improves, supported by better Child and Adolescent Mental health Services. **Every Child Matters: Change for Children** (Department for Education and Skills:2004): Every Child Matters identifies five key outcomes that services should be working towards for all children – being healthy, staying safe, enjoying and achieving economic wellbeing. Mental health is a key cross cutting element. **Youth Matters** (Department for Education and Skills: 2005): sets out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to. Youth Matters promotes a stronger focus on young people's physical and emotional health. **Care Matter: Time for Change** (Department for Education and Skills:2007): promotes positive mental health for children in care, to ensure the provision of targeted and dedicated provision that appropriately prioritises children in care. **A National Service Framework for Mental Health** (Department of Health:1999): sets national standards and defines service models for promoting mental health and treating mental illness, addresses the issues involving safe care of 16 and 17 year olds, including transition arrangements and meeting the adult targets for Early Intervention services and Suicide. **National Standards, Local Action** (Department of Health:2003): sets priorities for 2005/6 – 2007/8 for the NHS and emphasises the need to improve outcomes for individuals and to maintain the levels of service achieved the 2003-06 planning round. **Standards for Better Health** (Department of Health: 2004): sets out the level of quality that organisations providing NHS care will be expected to meet or aspire to. **Our Choice, Our Care, Our Say** (Department of Health:2006): sets out a vision to provide people with good quality social care and NHS services in the communities

	where they live. **Local Strategies** **'Improving the state of our minds' Emotional Wellbeing and Mental Health of Children and Young People in Plymouth Strategy** (2009 – 2014): developed in partnership across all agencies with supporting information/input from users and carers, aims to: • Improve all children and young people's mental health; • Develop a shared understanding and collective responsibility for children and young people's emotional wellbeing and mental health; • Ensure that agencies work in partnership to promote mental health, provide early intervention, and meet the needs of children and young people with established or complex problems. • Provide mental health care and support based upon the best available evidence, exceeds minimum core standards, is needs based and delivered by staff with the right range of skills and competencies. **The Health and Well-Being Strategy (2008 – 2020)** commits the city council and its NHS partners to continue in the mental health services for children and young people. Mental health promotion is one of five key priorities for Plymouth. These priorities are also reflected in the Plymouth Children and Young People's Plan (2008 – 2011) (CYPP) where improving children and young people's mental health has been identified as a key priority. Implementation of the CYPP is overseen by the Plymouth Children and Young People's Trust which, underpinned by the Children Act 2004 duty to co-operate, brings together all services for children, young people and their families to deliver better outcomes. Implementation of the CYPP is supported by the following local strategies which in turn have a contribution to make toward achievement of this priority. These include: A reduction in repeat assessments through coherent, efficient and shared use of common assessment framework (CAF) for children and young people around emotional wellbeing and mental health, especially with those at elevated risk of developing mental health problems.

	The CAF is an holistic approach to conducting assessment of a child or young person's additional needs which are not being met by the universal services they are receiving. A CAF provides an assessment that is common across services, and facilitates the process by which different agencies working with the same child can 'join'. Culture and practices within each school will strengthen with emotional literacy of school aged children and young people. After the family, schools are the most important organisation in the lives of the vast majority of children and young people, and as such are an ideal setting in which to nurture emotional wellbeing. Children who are emotionally or mentally healthy achieve more at school and are able to participate more fully with their peers and in school and community life. Equally, children with problems in this area have a diminished capacity to learn and benefit from their time at school. They can also adversely affect the social and academic environment for others in the school. Families will be engaged in activities that build their resilience and emotional literacy. Good parenting is fundamental for the development of a child's mental health and wellbeing. As children's primary carers, all parents need to be supported and helped, but especially when they are parenting in difficult circumstances or facing uncertainty about the way they are bringing up their children. All staff working directly with children and young people will have sufficient knowledge, skills, training and support to build and promote their emotional wellbeing. Parents, carers and everyone in day to day contact with children and young people need an understanding of child development, the causes of mental health problems and things they can do themselves to build resilience and deal with issues as they emerge, whatever age their child is.
Supersedes Document	This Operational policy supersedes previous CAMHS Operational policies as follows as part of the CAMHS redesign: CAMHS Plymouth Multi-disciplinary Team Operational Policy; CAMHS Outreach Team operational policy; Children in Care Operational Policy; CAMHS Severe Learning Disability Team Operational policy; Children's Day Program (Tier 4) Operational Policy.
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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New policy	June 2014	CAMHS Service Manager	This Operational policy supersedes previous CAMHS Operational policies as follows as part of the CAMHS redesign: CAMHS Plymouth Multi-disciplinary Team Operational Policy; CAMHS Outreach Team operational policy; Children in Care Operational Policy; CAMHS Severe Learning Disability Team Operational policy; Children's Day Program (Tier 4) Operational Policy.
1	Ratified	July 2014	Policy Ratification Group	Minor amends.
1.1	Additional information added.	January 2015	CAMHS Service Manager	Appendix F added.
1.2	Extended	June 2016	City Wide Locality Manager	Extended no changes

Complex CAMHS Operational policy

1. Introduction

1.1 Child and Adolescent Mental Health Services (CAMHS) promote the mental health and psychological wellbeing of children and young people. It provides high quality, multi-disciplinary mental health services to all children and young people with mental health difficulties and disorders to ensure effective assessment, treatment and therapeutic support for them and their families.

1.2 CAMHS is the provider of advice, consultation, assessment and therapeutic intervention at both targeted and longer term work for children and young people aged 5-18 years, across Plymouth.

1.3 The Children and Adolescent Mental Health Team consists of a range of qualified and experienced multidisciplinary clinician's covering a broad aspect of modalities including Nursing, Social Work, Psychology and Psychiatry. Embedded in the wider CAMHS framework are additional specialist teams for particular treatment pathways:

- Primary Mental Health.
- Infant Mental Health.
- Complex CAMHS Multidisciplinary Team.
- Community Outreach Team.
- Neuro-Developmental.
- Children's Day programme.
- Children in Care (Enhanced Service 5 – 19 Yrs supporting children who are within the care of Plymouth Local Authority and placed with Carers in specified area of Devon by commissioning body).
- Severe Learning Disability.

2. Purpose

2.1 The aim of this document is to provide an operational policy which describes the framework for Livewell Southwest (LSW) employees to follow when delivering intervention and considering identification of emerging and enduring mental health problems to the children and young people of Plymouth.

2.2 This document will outline the services provided by the CAMHS Community Facing Teams to those professionals in universal services in promoting the mental health and emotional wellbeing of children and young people.

2.3 It will outline the team processes from referral, delivery and clinical intervention to the training delivery for universal services.

3. Service Provision

3.1 CAMHs teams are based at different therapeutic sites within the geography of Plymouth as follows:

- Primary Mental Health Team – Plymbridge House, Plymouth.
- Infant Mental Health Team – Tamar Folk Children's Centre, Plymouth.
- Complex CAMHS – Revive, Mount Gould Hospital.
- Outreach Team – Revive, Mount Gould Hospital.
- Neuro-Development Team – Terraces, Mount Gould Hospital.
- Children's Day programme – Terraces, Mount Gould Hospital.
- Severe Learning Disability – Terraces, Mount Gould Hospital.
- Children In Care Team - Midland House, Plymouth.

3.2 CAMHS comprises of a large multi-disciplinary team with an extensive skills base including the following clinical staff groups:

- CAMHS Service Managers.
- Clinical Team Managers.
- Child and Adolescent Psychiatry.
- Child and Adolescent Psychology.
- Child and Adolescent Psychotherapy.
- Primary Mental Health Workers.
- Mental Health Practitioners.
- Occupational Therapists.
- Art Psychotherapy.
- Clinical Nurse Specialists (Mental Health).
- Family Therapists.

3.3 Skills available in the teams are:

- Early intervention in psychosis.
- Psychoanalytical psychotherapy.
- Supportive psychodynamic therapy.
- Solution Focussed Brief Therapy.
- Family Therapy and Family work.
- Cognitive Behavioural Therapy.
- Dialectical Behaviour Therapy.
- Behaviour Management and Parent Training programmes.
- The operation of the Mental Health Act and other legislation.
- EMDR (Eye movement desensitisation and reprocessing)
- Art Psychotherapy.
- Functional Assessment.
- Group Psychotherapy.
- Psychometric.
- Standardised assessment e.g.; ADOS, ADI, 3Di, DISCO.
- Psychotropic medication.

- Risk assessment and management.

4. Service Delivery

The Plymouth CAMHs Teams aim to deliver with the following objectives:-

- To triage referrals within 24 Hours through the Devon Referrals Support Services (DRSS).
- To operate triage Clinics – Where Initial Assessment and formulations occur by way of dual practitioner assessments in a succession of three clinical sessions.
- This will produce a robust formulated assessment to ensure that children and young people come in to the appropriate service for the appropriate pathway of care.
- Our intention is to assess within six weeks of original referral and 18 weeks to treatment.
- Children and Young People will be assessed and supported within the guidelines of the Care Programme Approach (CPA) under the definitions of Care Coordination or Standard Care. This will require regular reviews and will be measured and evaluated on an ongoing basis in line with LSW policy.
- The CPA approach produces a robust and timely process for on-going review and evaluates interventions against progress, by utilising and implementing outcome measures.
- We aspire to Work in a multidisciplinary way, integrating with staff from a range of settings e.g. Education, Social Care, Health, Substance Misuse, Youth Offending Services and Adult Mental Health.
- We aim to Increase accessibility by working in a flexible way, reaching into community settings and homes as appropriate.

4.1 Referral

4.1.1 All referrals for CAMHS are sent to Devon Referral Support Services (DRSS) (Appendix C). They are triaged by Senior Clinicians within the CAMHS team on a daily basis and within 24 Hours. If referrals are not accepted they will be returned to the referrer sign posting universal services that are considered appropriate. When a referral is accepted to CAMHS the case will be allocated to the appropriate pathway. (See Appendix D).

4.1.2 Specialist CAMHs, Neuro-Developmental and Primary Mental Health referrals go through to the Triage Clinics for Initial Assessment and formulation.

4.1.3 Urgent and Priority cases requiring an immediate response will go directly to the Community Outreach Team as a P2. (P2 Response will be within 7 Days, See Community Outreach Team Definition Pg12).

4.1.4 Referrals for Children that are in the Care of Plymouth Local Authority and live within the specified service area will go directly to the Children in Care Team, collocated with Social Care Teams at Midland House, Plymouth.

4.1.5 Referrals for children and young people with Severe Learning Disability (SLD) will go directly to the SLD team.

4.1.6 Referrals for Children who are under five years of age will go directly to the Infant Mental Health Team (IMHT).

4.2 Triage Clinics

4.2.1 Triage clinics consist of dual professional formulation and assessment sessions. Within these session clinicians will undertake a thorough systemic assessment considering the presentation of the child/ young person, chronology or developmental history, protective factors and supportive networks. Risk Assessments will be completed alongside Assessment paperwork. Three consecutive sessions are allocated for this process and will be defined on a case by case basis who attends the sessions depending on the child's age, need, context of presentation and assessment and formulation requirement. During these sessions other specialist clinicians can be requested to support the formulation such as psychiatry or nurse specialists.

4.3 Care Programme Approach (CPA)

4.3.1 The CAMHS team will support children and young people within the guidance of the CPA and the definitions of Care Coordination and standard care. This will be assessed at Triage but is flexible allowing the needs of the child and young person to fluctuate and be indicated by the level of support the young person is deemed to require at any given time.

4.3.2 The care program approach, assessing and care planning views a person holistically e.g. seeing and supporting the person as an individual and the needs they have including: Family: parenting: relationships: housing: employment: leisure: education: creativity: spiritually: self-management and self-nurture; with the aim of optimising mental and physical health and well-being. (Refer to Care programme Approach (CPA) and Standard Care Policy – Community CAMHS http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/C/CPA%20Pol%20v2.doc

4.4 Clinical Intervention

4.4.1 Following the outcome of the initial triage assessment and formulation an appropriate pathway of care will be identified.

4.4.2 The pathway of care will sit within the framework of CPA. At the beginning of treatment a care plan will be agreed in partnership with the children/young person and their family alongside an appropriate risk assessment.
Review of the care pathway and the progress made should occur every 6 to 9 sessions, and will include the child/young person, their family, and relevant professionals if appropriate.

4.4.3 All interventions will be recorded in the form of clinical entries to the electronic database. Written summaries and updates will be shared with the original referrer, General Practitioner and other relevant professionals as agreed and if appropriate.

4.4.4 The Complex CAMHS team provide specialist, bespoke, individual packages of care around highly complex mental health problems relating to, for example, Attachment Disorder, Eating Disorder, Post Traumatic Stress disorder, psychosis, anxiety, Obsessive Compulsive Disorder, Bipolar, complex trauma, post abuse therapeutic intervention, risk management, Depression, ADHD (Attention deficit hyperactivity disorder) and ASD (Autistic Spectrum Disorder).

4.4.5 Children and young people will be discharged from the CAMHs service when goals and outcomes of the clinical care plan have been met. The care plan is collaboration between clinician and the child/young person and their family if appropriate. Early discharge may occur in line with LSW DNA policy. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/R/Referral%20to%20Treatment%20Access%20v6.doc

4.5 Consultation

4.5.1 The definition of consultation adopted here is that consultation "is an activity in which one practitioner helps another through a process of joint enquiry and exploration. The work discussed remains the responsibility of the consultee, who remains in control of its direction, decision making and methodologies." Southall 2005. "Consultation is a collaborative exercise between professionals where one of them offers their professional expertise to others in such a way as to facilitate thinking and problem solving." Banhatti, Dwivedi in Southall 2005.

4.5.2 Consultation to all professionals in universal services is predominately provided by Primary Mental Health Workers in the team, both through individual and professional group consultations.

4.5.3 Consultation is a function of any clinician in the team and requires liaison with other professional agencies and services, encouraging a multi-professional and universal collaborative response to need.

4.6 Group Work

4.6.1 Group work is identified and tailored to our specialist population on a needs led basis and is constantly evaluated as to need and effectiveness against National Institute for Clinical Excellence (NICE) Guidelines and service demand. Specific thematic group work are identified and described in the specific team definitions.

4.7 Training

4.7.1 Specific training elements are defined within the team definitions. Training is predominantly facilitated by the Primary Mental Health Team, however specialist teams do facilitate specific pieces of training aimed toward their client group.

4.7.2 All training facilitation is reviewed and evaluated to ensure that its aims and objectives have been met by the required audience.

4.7.3 Any required bespoke training can be requested and delivered by CAMHS clinician's within the service framework.

5. Specific CAMHS Teams definitions

The CAMHS service framework has specialist teams within it that are commissioned to deliver specific types and focus of work. The team structure and definitions are following:

5.1 Neuro Developmental Team

5.1.1 All children and young people will have the same experience of the CAMHS are pathway, however during the journey on the pathway difficulties in determining specific diagnosable disorders may occur, due to the complexity of the presentation and possible co-morbid presentations. In these cases there are multi-agency meetings that can be accessed. These are in joint partnership with Paediatric colleagues from the Child Development Centre, with contribution from psychiatry and clinical nurse specialists from the multi-disciplinary Team.

5.1.2 The team accesses these in the first instance through consultation with the clinicians directly involved in the meetings, during which it is agreed whether these are the most appropriate aspects of the service to meet the needs of the child/young person. The clinician will be expected to have undertaken a comprehensive assessment, including school observations and seeking an educational assessment.

5.1.3 The team can access intensive assessment for a child/young person aged 5-13 from the CAMHS Children's Day Programme where there is a complex co-morbid neuropsychiatric presentation. These children/young people will have received a comprehensive assessment from the MDT. The team will access the Children's Day Programme for consultation as to whether the child/young person requires as assessment or intervention from a team whose provision is on an intensive level that runs on a day programme schedule. The Children's Day Programme eligibility criteria and operational policy can be consulted in order to support the teams understanding of the care pathway between each element of the service.

5.2 Children's Day Programme

5.2.1 The Children's Day Programme (CDP) provides assessment and intervention to children between the ages of 5 and 12 years and their families across the city of Plymouth. The CDP has two main aims and they are referred to separately within this document. They are to:-

- Provide assessment to children where there is a suspected neurodevelopmental/neuropsychiatric disorder, or complex emotional and behavioural presentation.

- Offer intervention when indicated following the assessment of children or to children and their families where there is a diagnosis of a neurodevelopmental disorder but the symptoms are impairing on their functioning within the family or school placement.

The Unit offers a highly specialised tertiary level service to young people with

the most serious mental health problems.

5.3 Service Provision

5.3.1 The Children's Day Programme offers an assessment and intervention service to 60 children per year. The age range of service users is after the fifth and to the young person's twelfth birthday. However in exceptional circumstances, when it is clinically and developmentally appropriate, admissions outside this age range may be considered.

5.3.2 Individual assessment and treatment plans are based on a developmental approach to the problems of children. This approach incorporates children's mental health issues, family context, cultural, social, and educational factors into the formulations.

5.3.3 The team use a range of assessment tools such as the Diagnostic Interview for Social and Communication Disorders, Autism Diagnostic Observation Schedule, Wechsler Intelligence Scale for Children (WISC IV). The CDP is co-run by health and education as agreed in the CAMHS service redesign of November 2009.

5.3.4 The multidisciplinary/agency team consists of the following professions:

- Discipline.
- Clinical Team Manager.
- Consultant Psychiatrist.
- Clinical Psychology Assistant.
- Occupational Therapist.
- Staff Nurse.
- Teacher.
- Teaching Assistant.
- Education Liaison Officer.
- Speech and Language Therapist.

5.3.5 The CDP provides planned assessment groups. Each group has up to 6 children for 2 days over a 3 week period. Following the assessment the family are offered a feedback meeting to discuss our formulation and recommendations. A multi-agency meeting is then convened to feedback the relevant information and recommendations to professionals involved with the family. A report will be circulated to the relevant family members and professionals. A post discharge group runs for up to 4 weeks for children and families to provide some psycho-education and support around the diagnosis, and the behaviour issues that arise within the home. Support is offered to the child's siblings, when the need arises.

5.3.6 The CDP offers a follow up support group to children and their families once they have completed the assessment or intervention. Bi monthly 'Drop In' groups are facilitated by CDP staff and a PMDT staff member. The purpose of the group is to provide a supportive, therapeutic space for children and families to think about the ongoing issues that having neuropsychiatric difficulties present. This is offered to families who have been through the assessment of intervention groups at the CDP and to Families identified in PMDT who would benefit from some additional support**.**

5.3.7 The team will also provide a consultation service for other professional colleagues.

5.3.8 The CDP will operate from Monday to Friday during the working week from the hours of 9am to 5pm, with the flexibility of working outside these hours to meet the needs of the children and their families, when clinically appropriate.

5.3.9 Eligibility Criteria

a) The Children's Day Programme:

Will consider referrals of children aged between 5 and 12 years who are suspected or known to have a complex neurodevelopmental/ neuropsychiatric disorder, who have previously received substantial input at Tier 3 level from clinicians in CAMHS or Community Paediatrics, and for whom:

- There is diagnostic uncertainty, or
- There is diagnostic certainty, but community and multi-agency input to date has been ineffective.

b) The Children's Day Programme:

- Will expect that referrers will resume case management once the Day Programme's task is complete.
- Will expect there to be multi-agency cooperation in the pre and post assessment phases of a child's contact with the Day Programme.
- Is expected to consider all referrals of children living within the Plymouth City Boundaries.

5.4 Pathway

5.4.1 Members of the day programme multi-disciplinary team will assess the young person at the first available assessment slot and a pre-admission network meeting will be arranged with the professionals from other agencies involved. Any decisions will be made as soon as is practical and the young person, parents/carers and referrers will be informed as soon as possible of the outcome.

5.4.2 Emergency referrals via the telephone are acceptable and, whenever possible, the assessment process would be telescoped to meet any urgent need for admission.

5.4.3 Where admission is deemed inappropriate, or agreement with the parents/carers cannot be reached, guidance on alternative services provided by the team, or by other agencies, will be offered to the family and/or referrer whenever possible.

5.4.4 Young people, parents/carers, referrers and other relevant agencies will be expected to participate in the process of assessing the most helpful responses and negotiating the treatment package devised and implemented.

5.4.5 The Unit Consultant will only automatically assume medical responsibility for a child for the period when they are actually attending the Day Programme and for up to 8 weeks following the assessment. Outside of this time responsibility rests with the CAMHS MDT.

5.5 Education

5.5.1 Wherever possible we support the child or young person in their usual educational environment.

5.5.2 The CDP has a teaching provision, which can provide a setting for re-establishing normative social and educational contact for children undergoing assessment of intervention. However it is not an alternative educational placement.

5.5.3 In addition the Teacher Education liaison worker also works closely with pastoral care, Special Educational Needs Coordinators and Parent Support Advisors within mainstream schools, as well as other outreach educational bases, to support, and ensure appropriateness of educational placements for children at the CDP.

5.5.4 The team work alongside other agencies to support reintegration to the child or young person's usual educational placement.

5.6 Community Outreach Team (COT)

5.6.1 The CAMHS Community Outreach Team has two main aims and they are referred to separately within this document.

They are to:-

- Provide acute, assessment and treatment in the community of young people between the ages of 5 and 18 years who are currently engaged with the Plymouth Multidisciplinary CAMHS team and where there is acute clinical escalation that may bring the team to seek possible inpatient admission; or provide a specialist and intense community response to those children and young people aged 5 to18 at the first point of contact with CAMHS whose mental health state requires an urgent response within 24 hours.

5.6.2 The COT Team provides a specialist clinical service in order to enable local mainstream CAMHS meet the needs of children and young people with complex difficulties and with the aim of reducing the number of admissions to the adolescent inpatient service by providing an alternative community focussed response in a mental health crisis.

5.6.3 The service is designed to be pro-active and community focused delivering interventions where ever appropriate to the needs of the child or young person. Visits to the family can be made with high frequency and variable duration. It operates flexibly in terms of having extended opening hours.

5.6.4 The CAMHS Outreach Team provides time limited intensive pieces of work for

children and young people with acute mental health difficulties. The package of care offered to young people includes working with their parents/carers where appropriate.

5.6.5 The team will also provide a consultation service for other professional colleagues.

- Provide for the rapid assessment of children and young people who present via Derriford Hospital Emergency Department due to incidents of self-harm within a “next day” standard. This aspect of the service is described in more detail in the policy “Protocol for the management of children and young people who present following self-harm to Derriford Hospital Emergency Department”.

5.6.6 The team provides assessment to any young person presenting at Derriford Hospital following an episode of self-harm. This service is presently extended providing a service to young people from Devon and Cornwall presenting at Derriford.

The team has an extensive skills base comprising of the following Clinical staff groups:

- Clinical Team Manager.
- Clinical Nurse Specialist (Mental Health).
- Mental health Practitioners (Nurse/Social Work).

5.7 **Referral criteria**

5.7.1 Children and young people who reside in Plymouth with a Plymouth GP can be referred by urgent referral or telephone contact directly to the team. Urgent Involvement (within 24 hours) will be agreed if considered appropriate by the clinical team. If the young person is not suitable for involvement with the COT team they will offer consultation with the referrer and may indicate other more appropriate services.

5.7.2 Children and young people who present to the Emergency Department (ED) of Derriford Hospital following self-harming behaviour and in need of a next day assessment. With the following caveats:

- Children and young people from Cornwall will be assessed and urgently referred on to the Cornwall CAMHS MDT for follow up.
- Children and young people from Devon will be assessed and urgently referred onto the “Devon CAMHS” team for follow up.
- Children and young people from Plymouth will be assessed and either retained for follow up in the CAMHS Outreach Team or passed back to the Plymouth Mulit-Disciplinary team or signposted to other agencies depending on the assessment outcome.

5.7.3 Those children and young people from Plymouth already in the CAMHS service whose situation deteriorates significantly, such as to place them at risk of admission to the Local Tier 4 Unit, or warrants a more intensive intervention than can be provided by the CAMHS Mainstream team alone. In this instance, it is expected that the Plymouth MDT Case Manager will initiate an urgent clinical discussion with the CAMHS Outreach Team.

5.7.4 If the factors listed below are the primary reason for referral, other more appropriate services should be given careful consideration where the Outreach Team may offer consultation or joint working.

- No permanent residence.
- Long history of substance misuse.
- History of serious and persistent violence.
- History of fire setting.
- Criminality/forensic history.

5.7.5 The Team will not be able to provide a service for young people who have:

- Severe behavioural disturbance or conduct disorder, in the absence of a treatable psychiatric disorder.
- Moderate to severe learning difficulties, in the absence of a primary diagnosis of mental health difficulties.
- Autism spectrum disorders, in the absence of a primary diagnosis of mental health difficulties.
- A primary diagnosis of substance misuse in the absence of severe and acute mental health difficulties.
- Need of secure accommodation, this should be provided by local authority secure children's homes or low/medium secure Specialist CAMHS psychiatric hospitals.

5.7.6 If the request for involvement does not meet the team's eligibility criteria the reasons for this will be discussed with the referrer and advice or suggestions made as to alternative provision.

5.7 Initial Assessment

5.7.1 We will meet with people in the community or wherever they feel most comfortable provided it is safe for staff and maintains confidentiality.

5.7.2 Alongside risk screening this assessment will determine the seriousness and urgency of an individual's difficulties and the most appropriate type of treatment for the client. This assessment is used to inform allocation of intervention and case worker, Structured Care Planned treatment and Crisis contingency planning.

5.7.3 The team will work within the Care Coordination (CPA) framework and Common Assessment Framework (CAF).

5.7.4 A more comprehensive assessment will follow to determine the precise nature of

the young person's mental health needs, including co-existing health conditions or social problems, to enable an individualised care plan to be prepared.

5.8 **Care Planning**

5.8.1 Where appropriate, care planning will involve the young person's family/carers and other services already working with the young person and as part of this process, their views and needs will be taken in to account. This is subject to the young persons consent.

5.8.2 The formulation of a care plan will be in collaboration with the client, which identifies the needs and goals of the client and seeks to address these.

5.8.3 The young person's care coordinator/lead professional will regularly review and, where necessary, agree changes to the care plan.

5.9 Review of Cases

5.9.1 All cases are subject to periodic review usually at 6 weekly intervals. Young people are expected to participate in the review process, their parents/carers and other professional involved will be invited and positively encouraged to participate in this process through regular meetings.

5.9.2 Summaries and other relevant information will be supplied to referrers at agreed intervals.

5.9.3 The negotiation of the treatment packages always takes account of the need to provide a safe environment.

5.9.4 There are three treatment stages.

5.10 Organising principles.

5.10.1 No single approach is effective in isolation. A basic aim of the approach is to stop the family from being placed in the position of handing over responsibility for the young person in crisis to psychiatric teams and inpatient units.

- Stage 1

Engagement with the family and child/ young person including the setting up of contingency and risk management plans. Mobilising the family network and conducting an intensive and thorough assessment with the aim of negotiating the correct intervention.

- Stage 2

Middle phase and delivery of interventions as assessed. Monitoring of progress and maintenance of engagement, helping the family restore its containing function in relation to the young person in crisis. Interventions to assist child/young person adopt more appropriate, normative activities.

- Stage 3

Ending phase where the focus is on negotiation with other agencies such as education, to promote a handover to local services. Development and rehearsal of strategies designed to prevent relapse.

5.11 Discharge

5.11.1 The Community Outreach Team will make the decision to discharge in negotiation with parents/carers, referrers and the young person. This decision will take account of the treatment goals negotiated at referral and any subsequent reviews.

5.11.2 The CPA will be used, creating a framework for discharge planning and aftercare. It will help to ensure that several principles of good practice are realised, including systematic planning, recording and reviewing the young person's care and support, as well as ensuring a proactive approach is taken to provide a swift and appropriate response if a young person's mental health deteriorates.

5.11.3 Discharge planning will form an integral part of the young person's care plan. Liaison with other involved agencies will take place early in any work undertaken to ensure continuity of care.

5.11.4 Prior to any discharge from the CAMHS Outreach Team an aftercare plan will be agreed with the young person and their family/carer and this will include a contingency plan identifying risk factors, warning signs and actions to be taken in the event of any difficulty occurring after the discharge back to the GP or other treatment agency.

5.11.5 Referrers will routinely be sent a discharge package containing a synopsis of the case, interventions undertaken and recommendations for any ongoing care the young person or their family might require. The multidisciplinary team will prepare this subsequent to the pre-discharge network meeting.

5.12 Hospital admissions

5.12.1 The team will work with the young person to avoid hospital admission wherever possible seeking alternatives where it is safe to do so and looking at all alternatives. We will work flexibly to enable them to stay at home wherever possible.

5.12.2 When admission is necessary we will always work with the young person and their family/carer to achieve this in the least restrictive way and aim to reduce the length of admission.

5.12.3 The team will liaise and coordinate admissions with other agencies as required to provide a smooth transfer to hospital. We will continue to visit the young person regularly and support them with advocacy issues, ward rounds, Mental Health Act information etc. Our goal is for them to return home at the earliest opportunity and will endeavour to be flexible enough to achieve this.

5.13 Children In Care (CIC) Team

5.13.1 Within the CAMHS structure is a dedicated CAMHS team for children and young people, aged 0-19 years, looked after by the local authority. Due to the early disrupted attachments and often significant abuse in their early years, requiring being received into local authority care, these children and young people are significantly at risk of complex mental health problems. Their presentations can include complex developmental trauma, acute symptoms of trauma, substantial acting out behaviour to include self harm and violence to others. These problems are compounded at times by neuro-developmental disorders in addition to the above. These children present extreme challenges to their carers and are likely to find it difficult to access education and are at risk of social exclusion and poor health outcomes.

5.13.2 The CAMHS Children In Care team is a co-located team working in partnership with the local authorities Children Services and is a clinical project commissioned by the local authority to deliver a range of services to children and young people looked after by Plymouth local authority within the geographical boundaries of Plymouth Hospitals NHS Trust.

5.14 Service Provision

5.14.1 The CAMHS Children in Care Team is located in Midland House and is co-located with Plymouth Children's Services, Children in Care Social Work teams. It is a targeted team providing a range of multi-disciplinary skills to a vulnerable group of children and young people who may have emerging and enduring emotional and mental health problems due to the impact of the care they have received whilst with their birth families.

5.14.2 The team has an extensive skills base comprising of the following clinical staff groups:

- Clinical Team Manager.
- Clinical Psychology.
- Clinical Nurse Specialist (Mental Health).
- Family Therapy.

5.14.3 Skills available in the team are:

- Early identification and intervention of mental health difficulties.
- Psychoanalytical psychotherapy.
- Brief Dynamic Therapy.
- Family Therapy and Family work.
- The operation of the Mental Health Act and other legislation.
- Psychotropic medication.
- Risk assessment and management.

- Narrative Story Stem Assessment.
- Dyadic Developmental Psychotherapy.
- Psychological Intervention and assessment.

5.15 Service Delivery

5.15.1 The CAMHS Children in Care Team aims to deliver with the following objectives:

- Highly specialist, systematic clinical provision for looked after children and young people who have severe, complex, and enduring mental health and emotional wellbeing problems; and their carers.
- Provide specialist advice, training and consultancy to Local Authority Children's Services to include; social worker, foster carer and professionals in other agencies supporting Children in Care in Plymouth Local Authority care.
- Provide access to additional intervention from other CAMHS teams as and when appropriate.
- Provide clinical advice to the Commissioners for children placed Out of Area, where appropriate.
- Provide training and consultation to Social Work Teams and Plymouth City Council Foster Care Service to assist in early identification and recognition of mental health issues and techniques for intervention at a non-specialist level.
- Produce reports for, and /or attend child protection case conferences and Looked After Children Reviews, as appropriate.
- Provide consultation to adoption social workers up to the completion of an adoption placement order.
- Work in partnership with social care to deliver permanence planning and re-unification with parents and carers.
- Provide enhanced service to band 4 foster carers which includes:

    1. Attendance to support groups for foster carers.
    2. Coordination and attendance at Team Around the Child (TAC) meetings.
    3. Direct consultancy and support to foster carers.

5.15.2 Consultation is provided as requested by children in care social workers and is accessed by direct request to a clinician or via the team secretary. Consultation is offered both to provide information as to whether a direct request for CAMHS Children in Care Team is recommended and as a process by which the team can support the ongoing care planning and network support of children in care.

5.15.3 Foster Carer Consultation/Intervention is provided by the team on receipt of this specific request and can be both alongside, and in support of, a direct therapeutic intervention with the child/young person or in support of the parenting of the child/young person with complex needs and presentation but where a direct therapeutic intervention is not indicated.

5.15.4 Consultation is also provided to other professionals in agencies providing support to children in care and can be accessed via a request to the team and where consent to share information has been agreed by the childs' social worker where there is an interim or full care order, and the parent when appropriate if the child is voluntarily placed.

5.15.5 The CAMHS Children in Care Team is not commissioned to deliver foster carer consultation/intervention for foster carers in Independent Fostering Agencies. However, if the team is providing direct assessment and/or intervention for the child or young person placed with a foster carer in an Independent Agency, consultation and advice will be provided to support the mental health and emotional well being of the child/young person and their ongoing care from the team.

5.16 Clinical Intervention

5.16.1 The team is commissioned to deliver direct assessment of 80 children and young people per financial year.

5.16.2 Individual work arises from the requests for involvement directly received by CAMHS Children in Care Team from a child/young persons social worker working with the child or young person, and their foster carers, where the request meets the eligibility criteria (Appendix D) for the service. The requests can result from advice and consultation as described above or as an urgent request. The team works on a priority response dependent on identified risk. Where a response is required within 7 days the need will be met by the team and an urgent appointment offered by an appropriately skilled clinician within the time frame stated. Routine requests will be responded to as per the referral to treatment guidelines.

5.16.3 Where a request for involvement does not meet the criteria a consultation will be offered to the social worker for the child/young person to help consider what support/intervention would be appropriate to meet the needs at the level described.

5.16.4 On receipt of an appropriate request actions will be considered based on the description of the child/young persons or foster carers needs. These can be as described below:

- Facilitation of a triangular consultation meeting with Social Worker, Foster Carer and Supervising Social Worker.
- Initial Assessment appointment offered to the child/young person.
- Ongoing consultation for Social Worker.
- Attendance at TAC meeting as appropriate and/or indicated.

5.16.5 The plan of care is reviewed on a regular basis, usually 6 sessions or 6 appointments and the care plan readjusted as appropriate.

5.16.6 The team will work within the Care Coordination (CPA) framework.

5.16.7 Consultation and attendance at TAC meetings do not require the child/young person to be an open case to the team and are therefore not ‘referrals’. Where consultation and attendance at meetings are initiated these will be recorded as single contacts on the electronic recording system.

5.16.8 The outcome of initial assessments will determine whether ongoing direct

therapeutic intervention with the child/young person is required. If, on assessment, no direct intervention with the child is indicated and/or consultation/intervention with the foster carer is identified to support the parenting of the child those consultations will be recorded as single contacts.

5.17 Pathways

5.17.1 The CAMHS Children in Care Team will often have to access other disciplines and specialities from the wider CAMH service in order to meet specific needs of the child or young person. These teams include:

- CAMHS Plymouth Multi-Disciplinary Team.
- CAMHS Children Day Programme.
- CAMHS Infant Mental Health Team.
- CAMHS Community Outreach Team.
- CAMHS Severe Learning Disability Team.

5.17.2 Please see team definitions and the CAMHS Community Facing Teams Operational Policy.

5.17.3 The Plymouth Multi-Disciplinary team should be accessed for medical input for a looked after child or young person and this is through direct consultation with the Consultant Psychiatrist in the team. Where ongoing medical input is required the case manager will remain as the clinician in the Children in Care Team who will co-ordinate all aspects of the child's mental health care and care planning, in joint partnership with the Consultant Psychiatrist.

5.17.4 Additional therapeutic modalities can be accessed in the PMDT with case management remaining in the Children in Care Team as described above. These additional therapeutic interventions, not found in the Children in Care team, are by consultation and negotiation with the team and its management.

5.18 Training

5.18.1 The CAMHS Children in Care Team delivers a number of trainings for Plymouth Local Authority Foster Carers who have the care of children and young people in Plymouth Local Authority Care.

5.18.2 'Fostering Attachments for Looked after Children' – an eighteen week three module attachment theory and parenting training group for foster carers. A training designed by Dr Kim Golding, Clinical Psychologist (2006).

- Module 1 Attachment Theory.
- Module 2 A Model for Parenting the Child with Attachment Difficulties.
- Module 3 Building Relationships and Managing Behaviours.

5.18.3 This training is designed to enhance and build capacity in foster carers to understand the complexity of the child's early developmental trauma and the impact this would have on their emotional and psychological development and formation of attachment relationships. In providing this training and knowledge base the teams aim is to help enhance the child's placement and reduce

placement breakdowns as a result of lack of knowledge of the child's difficulties.

5.18.4 On completion of the training modules the foster carers are provided with consultation group opportunities to further enhance their skills and bring theory to practice.

5.19 Band 4 Foster Carer Provision

5.19.1 Plymouth Local Authority Foster Carers are separated into banding 1-4 based on the level of training, knowledge and skills they have.

5.19.2 The CAMHS Children in Care Team are commissioned to deliver an enhanced service provision to Band 4 foster carers who are considered to be providing a high level of parenting for significantly complex children and young people who may not in other circumstances remain in a foster placement. The service provided by the CAMHS Children in Care Team is that of:

- Attendance to Foster Care Support Group When Requested.

- These are open groups for identified foster carers in the Band 4 scheme. The support groups are carer led with a view of CAMHS being available to them when required.

- Direct work with carers.

- This is direct work with the band 4 carers in relation to their role as a foster carer. This direct work may be in relation to a specific difficulty in the placement or something in their own life affecting their fostering task. This input is required to be reviewed regularly due to the demands placed on the team by this particular group.

- Team around the child meetings (TAC).

- It is considered that the CAMHS Children in Care Team should attend these meetings for Children in Care, particularly if the child is known to the team.

- Supervision to social workers.

5.19.3 The team provides monthly supervision for two Supervising Social Workers for Band 4 foster carers.

5.19.4 The demand estimated for the Band 4 service provision is split across the capacity in the CAMHS Children in Care Team with ongoing review with the Clinical Team Manager, the Clinical Team, and the Fostering and Adoption Service Manager.

5.19.5 The support to the Band 4 foster carers is to enable them to care for children with complex needs who would otherwise have to be placed with Independent fostering agencies or in residential units. When this happens often links are difficult to sustain with their birth family / school / support networks. These children are often dealing with their own emotional difficulties and the behaviours

they exhibit are challenging.

5.19.6 The Band 4 carers are required to have a certain level of related skills to enter the scheme and the expectation is that they will be able with others to enable Children and Young people through placement stability and support to not only be safe but also to look at improving their mental health, improve attainment and raise their aspiration alongside having fun. All Band 4 carers are expected to have completed the 3 module 'Fostering Attachments in Looked after Children' Training provided by the team.

5.20 Reunification

5.20.1 The CAMHS Children in Care Team are able to offer consultation regarding reunification of children and young people to their birth parents and, through consultation with the social worker, determine whether a direct referral to the team is indicated for assessment and therapeutic intervention with the child/young person and their birth parents. There is a small number of criterions to take into consideration in determining this:

- The child has identified mental health difficulties/symptomatology or is at risk of developing these through increased levels of stress associated with reunification.
- Child has been away from the care of the identified parent for reunification for a minimum of 6 months.
- There are a number of identified complex factors which may impact on the success of reunification and therefore warrants multi-agency monitoring and support.
- There have already been a series of failed reunification attempts.

5.20.2 The team offers a number of different approaches to working with families and the support network around them and can be offered up to 12 months post-reunification. Currently the service that we offer includes:

- Consultation to professionals regarding assessment of viability of reunification and support needed.
- Assessment of children's mental health and emotional wellbeing.
- Therapeutic support to children and/or birth parents as part of a reunification package.
- Time limited family therapy work.
- Participation in ongoing risk management multi-agency meetings when the team are actively working with the child/young person.

5.20.3 Only where the team are directly assessing and working therapeutically with a child/young person and their birth parent will the child be open to the team. Consultation for the social worker and/or professional network does not indicate an open case to the team; this will only be on referral of the child/young person and assessment of their mental health and emotional wellbeing in support of a reunification package. The team does not work solely with the birth parent.

5.21 Severe Learning Disability Team

5.21.1 The service provided by the CAMHS Severe Learning Disability Team includes short term and longer term interventions for children and young people with acute and chronic mental health difficulties. The package of care offered to young people includes working with their parents/carers, teachers, social workers, etc. where appropriate.

5.21.2 The team also provides a consultation service for other multiagency professionals and interagency colleagues in relation to the mental health needs of these children and young people**.**

5.21.3 The CAMHS Severe Learning Disability Team is a part of Livewell Southwest's Children's and Family Health Directorate. The Service operates within the guidelines, policies and procedures produced by LSW. All operational support will be LSW approved.

5.21.4 The team has an extensive skills base comprising of the following clinical staff groups:

- Clinical Nurse Lead.
- Consultant Psychiatrist.
- Occupational Therapist.
- Learning Disabilities Practitioner.

5.21.5 The Severe Learning Disability team work within the following premise:

- To ensure children with severe or profound learning disabilities have equitable access to mental health services for children and young people.
- This team work with children with complex needs who are at greater risk of their emotional and mental health needs going unrecognized or treated.
- To improve the quality of life of children with severe learning disabilities by providing a range of effective, evidence based interventions.
- To support families and carers by empowering them to further develop skills in caring for their child.
- To help to prevent family, placement and/or school breakdown by provision of timely intervention.
- To enhance the experience of children and young people with severe learning disabilities and emotional and mental health needs in all settings by supporting, advising and training professionals working with children and young people in the community.
- Support with the creation of competent environments and systems development.

- Parent/staff training, consultancy, development, reflective group, supervision.

- Provision of post discharge follow ups as appropriate.

5.22 Referral Criteria and Process

5.22.1 Definition of Severe Learning Disability:

5.22.2 Cited below are the definitions of learning disability but the Multidisciplinary Team (MDT) engages with children and young people who have the most severe learning disabilities as defined by the British Psychological Society.

5.22.3 Within the broad definition the British Psychological Society defines severe mental impairment as:

- Arrested or incomplete development of mind.

- Severe or significant impairment of intelligence. A mental impairment is defined as IQ 55-69 and severe mental impairment IQ of 54 and below.

- Severe or significant social functioning is defined as the individuals' skills and ability independently to provide for his/her own eating and drinking needs, keeping him or herself, clean, warm and clothed. Significant impairment means requiring partial help to meet the needs specified above and severe impairment requiring continued assistance in meeting the needs above.

5.22.4 According to these criteria the SLD team sees children with severe mental impairment and severe impairment of social functioning. The disabilities are often accompanied by sensory difficulties, little or no speech and communication, mobility difficulties, complex health needs, behavioural difficulties, the consequences of extreme prematurity, cerebral palsy and Downs Syndrome.

5.22.5 However, cognitive testing of these children is extremely difficult and unreliable; most would score as untestable on psychometric tests. Most children locally with SLD attend Mill Ford or Downham School. Some children attend Woodlands School and others mainstream schools with a high level of support.

5.22.6 In practice the eligibility criteria for the teams input indicates children who attend Mill Ford or Downham schools or who would be eligible to do so.

5.22.7 Children with a severe/profound learning disability aged 0 – 18 residing in Plymouth with a Plymouth G.P who are experiencing additional emotional, behavioural or other mental health need such as:

- Bereavement/loss.
- Stress.
- Anxiety.
- Obsessions.

- Compulsions.
- Changes to sleep pattern, particularly sleep deprivation.
- Mood changes.
- Depression.
- Psychosis – including schizophrenia and bipolar disorder.
- Tourettes syndrome.
- Autism.
- ADHD.
- Surviving abuse.
- Identity issues, confidence, self esteem.
- Functional analysis of behavioural distress, including physical aggression to others and self-injury, these behaviours would need to meet Emerson's definition (behaviours of such frequency, intensity or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of ordinary facilities).
- Risk assessment and risk management as part of a multi-agency response to life threatening behaviours, where the intent to harm oneself is not the primary motivation, i.e., pica behaviours (eating inedible objects), severe head to surface self-injurious behaviours of such frequency, intensity and duration that the child/young person places him/herself at high risk of further physical trauma.
- Psychological issues with eating well.
- Attachment difficulties.
- Treatment plans that include the use of psychotropic medication.
- Medication reviews.
- Analysis of complex epilepsies that impact on behaviour and well-being where there is a working hypothesis that the epilepsy presentation could be a demonstration of behavioural distress as the result of an unmet emotional or psychological need rather than an organic cause.
- Severe perseveration difficulties.

5.23 Children's Integrated Disability Service

5.23.1 The Children's Integrated Disability Service (CHiDS) is a new development in Plymouth, incorporating services delivered by Plymouth City Council (PCC), Plymouth Hospitals NHS Trust and Livewell Southwest.

5.23.2 CHiDS provides a multi-disciplinary approach to services for disabled children and young people and their families who are aged 0-18 and live in Plymouth.

5.23.3 The Single Point Of Contact (SPOC) is the main route of access to multi agency services within Plymouth's Integrated Disability Service and the Child Development Centre.

5.23.4 The CHiDS intake meeting takes place on a fortnightly basis and is attended by the Clinical Team Manager of the Severe Learning Disability Team, CAMHS in order to receive referrals and co-work with other agencies/disciplines.

5.23.5 The SPOC co-ordinator will check that informed consent to share information

has been given and will subsequently inform parents/carers when the intake meeting will take place.

5.23.6 Purpose of the meeting.

- To offer early identification and assessment at the earliest stage.
- To provide carefully planned collaborative work and support across CHiDS services with the unique needs of children and their families at the centre of all decisions.
- To support and streamline communication processes so that families do not have to keep repeating themselves.
- Opportunity for specialist multi agency professionals to identify and plan both immediate and future service provision for children and young people who are likely to require multi agency support from CHiDS teams.
- Individual teams will receive referrals and will have the opportunity to discuss criteria and waiting times for their services, etc. This enables provision to be planned, coordinated and seamless throughout transitions.
- An appropriate Team Around the Child (TAC) will be established.
- The SPOC coordinator will contact the family to arrange a TAC meeting and identify an appropriate Early Support keyworker as needed.

5.23.7 The Severe Learning Disability Team are an integral team making up the integrated service.

5.23.8 Additional services that are integral to the service are:

- Specialist services working within the Child Development Centre (PNHT).
- Special Services (SEN administration) PCC.
- Social Work (PCC).
- Occupational Therapy (PCC).
- Sensory Advisory Team (PCC).
- Communication Interaction Team (PCC).
- Early Years Inclusion Service (including Portage and early support) (PCC).

5.24 Service delivery

- Provision of a local, community based service.
- Support children at home with their families and avoid the need for hospital or social care admissions.
- Find ways to reduce the level and frequency of the behavioural distress that present a severe challenge to the child/young person, families and services.
- Recommend appropriate long-term packages of support to prevent the re-emergence of such behavioural distress.
- Support parents and carers to enhance skills specific to meeting the needs of the child.
- Prevention of school placement breakdowns, to ensure children's needs can be met within the city and prevent out of area placements.
- Prevention of crises in the family home that could result in a child becoming looked after by the local authority.
- Early intervention to prevent chronic emotional and mental health difficulties

that impact on all aspects of the child's life.

- Prevention of social isolation by identification and management of factors likely to lead to further isolation.
- Identification of underlying health needs that present as emotional distress, ensuring appropriate and timely treatment, a study in 1995 found 92% of children with a severe/profound Learning Disability had a previously undetected but treatable physical health conditions.
- To ensure that self-injurious behavioural distress do not result in permanent additional disabilities, such as detached retinas, severe tissue damage requiring restorative surgery.
- Provision of training to enhance the systems supporting the child.
- Maximising achievement of potential and quality of life for the individual and family.

5.24.1 Support is usually offered within a multi-agency framework to ensure holistic plans of care are individually assessed and implemented.

5.25 Training

5.25.1 The Severe Learning Disability Team is committed to providing both formal and informal training to a wide range of participants, i.e., professionals within CAMHS, partner agencies and families/carers.

5.25.2 Training can be subject specific or bespoke to the individual needs of the child/young person.

5.25.3 Training given includes:

- Positive Behaviour Support.
- Risk assessment.
- Risk Management.
- Autism.
- Autism and distressed behaviour.
- Crisis intervention.
- Mental Capacity Act.
- Sleep and children with Severe Learning Disability.

5.26 Youth Offending Service

5.26.1 Clinical Nurse Specialist for Youth Offending:

5.26.2 This post is linked to the Youth Offending Service within Services for Children and Families, Plymouth City Council. It is provided within the youth offending team to identify where there are mental health problems within this population of young people. It has been identified that this population are three times more likely to develop mental health problems requiring a CAMHS intervention. The post is commissioned to promote engagement of vulnerable children and young people who would not ordinarily access a CAMHS Service.

5.26.3 As soon as a court order has been presented the child/young person has an

assessment by the Youth Offending Officer and if that assessment highlights emotional or mental health difficulties an automatic request for involvement is directly sent to the Clinical Nurse Specialist.

5.26.4 The post directly integrates with the wider team where the child or young person requires diagnosis and prescribing and/or a complex and multi-disciplinary plan of care.

6. Clinician Processes

6.1 Clinical and Case Management Supervision:

6.1.1 All individuals are required to follow the practice guidelines of their profession and the policies of their employing Trust (e.g. Nursing and Midwifery Council, April 2008). This applies to the practice of the receipt and delivery of clinical supervision referred to in http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/C/Clinical%20Supervision%20v3.1.doc

6.1.2 Clinical supervision is distinct from other forms of management and supervision. These include Line Management Supervision, Caseload Management Supervision and Professional Leadership. A number of LSW policies relate to the various forms. Clinical supervision is not a management control system and disciplinary procedures should be distinct and separate from the practice of clinical supervision. However, it is appropriate for managers to be informed that clinical supervision is taking place and that the arrangements are satisfactory, as a minimum on an annual basis at the Annual Appraisal.

6.1.3 Case management supervision is provided by the clinical team manager to all clinicians in the team whom they have line management responsibility for. It is a process by which the clinician can be helped to manage their case load in an effective and safe manner that takes into consideration demand and capacity and job planning. This is provided on a monthly basis for all clinicians.

6.1.4 Caseload Management Supervision is:

- The process used where the care coordinator/case worker reviews each of the individual clients/service users on their caseload, with their line manager.
- A regular, structured process, which aims to be both challenging and supportive.
- Designed to ensure that the individual caseworker is maintaining a caseload of a suitable size, with individuals who have active needs, and that appropriate support and clinical supervision is being provided/received.

6.1.5 The level of supervision provided must not fall below the minimum agreed standards and arrangements must allow sufficient resources (including time and location) to support staff engagement in the practice of supervision.

6.2 Group Supervision

6.2.1 Staff groups are encouraged to partake in group supervision. This may be led by modality or thematic need such as CPA supervision groups that are run on a weekly basis for all team members. Modality group supervision may take place on a monthly basis for particular professional groups such as Psychology, Nursing, Family Therapy, Psychodynamic.

6.3 Continued Professional Development

6.3.1 All individuals are required to follow the practice guidelines of their profession and the policies of their employing organisation (e.g. Nursing and Midwifery Council, UKCP BACP). Professional registration will require identified CPD to their professional registration which must be adhered to by registered staff in line with LSW professional registration policy. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/P/Professional%20Registration%20v1.3.doc.

6.3.2 Plymouth CAMHS also facilitate in house CPD events every month. The context of these will vary and can cover specialist themes facilitated by members of the team or invited guests/speakers from external agencies.

6.3.3 Staff members will be expected to attend a minimum of 6 CPD events per year and will be recorded by attendance signatures.

6.4 Appraisals/PDPs

6.4.1 CAMHS staff will undertake an annual appraisal in line with LSW Appraisal policy and procedures. This is undertaken by staff team line manager. **http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/A/Appraisal%20mgt%20supervision%20v2.9.doc**

6.5 Staff Induction/Mandatory Training

6.5.1 All newly appointed staff undergo a comprehensive induction programme. The programme will be designed around the area of work and the team designation. This will include an introduction to all the teams within the CAMHS service and the wider universal services.

6.5.2 All staff will undertake the LSW's Induction and mandatory training. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/C/Corp%20Ind%20mand%20Trng%20v2.doc

6.6 Safeguarding

6.6.1 CAMHS safeguarding procedures will be defined by the LSW Policies and Procedures. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/S/Safeguarding%20Children%20Policy%20v1.1.doc and the South West Safeguarding and Child protection procedures. Reconstruct Online Procedures - South West Safeguarding and Child Protection Procedures | South West Safeguarding and Child Protection Procedures . LSW is signed up to south west regional child

protection procedures. These can be accessed at www.swcpp.org.uk.

6.6.2 Safeguarding supervision is provided by the clinical team lead trained in safe guarding supervision as directed through the LSW CAMHS Safeguarding Children Supervision Policy. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/C/Child%20Protection%20Supervision%20Policy%20Version%201.docx

6.6.3 This will also require safeguarding and protection of adults in line with LSW policy. http://plysab.proceduresonline.com/chapters/contents.html

7. Monitoring Compliance and Effectiveness

7.1 All CAMHS teams are required to complete a minimum data set collection Identified by the CAMHS Outcome Research Consortium (CORC). These measures identified are Strengths and Difficulties Questionnaire (SDQ), Clinical Global Assessment Scale (CGAS), Health of the Nation (HoNosCA) and Goals Outcome Sheet.

7.2 All CAMHs clinicians will be required to undertake routine outcome measures, including session by session, goal based or modality specific. Further information can be seen at http://www.corc.uk

7.3 The team is accountable to CAMHS Patient Safety and Quality Committee (PS&Q) for its quality assurance and clinical effectiveness. The team adheres to Clinical Governance outlines as defined in LSW Policies and Procedures and CAMHS PS&Q.

8. Representation and Complaints

8.1 Representation and actions relating to team decisions should be brought to the attention of the Clinical Team Manager in the first instance and then shared with the Complaints department in line with LSW policy and procedures. http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Policies/C/Complaints%20Policy%20v9.6.doc

8.2 Where a complainant is dissatisfied with the actions/decisions of the team this will be referred to LSW litigation and complaints as per LSW policies and procedures.

8.3 Copies of the complaints procedure are available for professionals through the team and service, as is information for children/young people and their families.

All policies are required to be electronically signed by the Lead Director. Proof of the e-signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

Signed: North West Deputy Locality Manager

Date: 19/09/2014

Appendix A

CAMHS referral Template Criteria. V.1.

Plymouth CAMHS provides specialist mental health assessment and treatment to children and young people registered with a Plymouth GP who have significant, complex or enduring emotional or mental health difficulties.

What CAMHS Provides:-

CAMHS deliver services for CYP aged 0-18 years (19 years if within the care system) these range from:

Early Intervention

This involves early detection and provision of preventative support to children and families in need. Intervention at this stage is provided to children and young people who are experiencing early difficulties; and/or mental health and emotional difficulties; or engaging in risk behaviours which are progressively impacting the child's young person's and and/or families psychological/social/educational functioning.

Longer term work

This can involve specialist diagnostic assessment and the provision of the psychological, systemic and/or pharmacology therapy. Intervention at this stage is provided to the children and young people who are experiencing moderate to severe mental health and emotional difficulties which are having a significant impact on daily psychological/social/educational functioning.

Exceptions to this will be considered on an individual basis and will not apply to those responses that are required to be rapid – i.e. same day, next day, 7 day requests for assessment due to escalating risk.

CAMHS clinicians are appropriately qualified and have experience in a variety of fields including Child and Adolescent Psychiatry, Clinical Psychology, Occupational Therapy, Psychotherapy, Family Therapy, Mental Health Nursing, Creative Therapies, Social Work Paediatric nursing.

Following acceptance of referral CAMHS clinicians will decide the appropriate clinical pathway for that individual.

Prevention

Consultation needs to happen with consent from the parent/carer/YP

Professional to Professional consultation can be used to discuss a case, where there are concerns about a YP mental health.

Triangular consultation can be arranged via the school, a member of school staff needs to present alongside a parent and primary mental health worker. To arrange a Triangular consultation contact the PMHW on 01752 43160.1

Group consultation where teams of professional can meet with a member of CAMHS to discuss multiple cases they may be concerned about.

Professional advisory line 01752 431613. Available weekdays 12-1pm. Cases can be discussed anonymously with a primary mental health worker, this service is available to all professionals that work with CYP the YP doesn't need to be known to MH services

Rapid Response

Contact the practitioners within the CAMHS rapid response pathway on 01752 435122 to determine whether response is required within 24 hours maximum. This may include;

- CYP that are an imminent risk to themselves or others due to a deterioration in their mental health.
- Have active thoughts and plans of suicide with intent.
- Are suffering acute psychotic symptoms.
- Those who are severely depressed and/or in need of crisis assessment and intensive home treatment to prevent admission to hospital.

Referral Criteria

Complex Developmental Problems/Attention Deficit Hyperactivity Disorder & Autistic Spectrum Disorder

Difficulties may include:

Impaired social communication
Unusual or very fixed interests
Marked preference for routine and difficulties adapting to change or rigid behaviours

- Complex ADHD cases with mental health disturbance should be referred to specialist CAMHS.
- ASD cases with mental health disturbance should be referred to specialist CAMHS.

Eating Disorders

- Anorexia – At least 10-15% deficit from ideal weight.
- Bulimia – Engaging in binge and purge behaviour.
- Eating Disorders Not Otherwise Specified (EDNOS).

Psychotic Illness

- Positive symptoms – Paranoia, delusional beliefs, abnormal perceptions (hallucinations on all sensory modalities).
- Negative, symptoms – deterioration in self care and daily personal, social and family functioning.
- Disinhibited behaviour, hyperactivity, risk taking, with pressure of speech and Agitation.
- Severe depression with psychomotor retardation, social withdrawal, suicidal

Ideation.

Anxiety Disorders
Where it is affecting the CYP development or level of functioning.
Where it is out of proportion to the family circumstances.
Where there is an impact on the parent/carer/child relationship.
Where there is a sudden change or deterioration.

- Anxiety panic attacks
- Separation anxiety
- Phobias including phobic anxiety related to school

Depression

- Cognitive symptoms – negative thoughts about self /others /world
- Suicidal ideation – level of intent, current thought, plans etc.
- Co-morbidity – depression often occurs concurrently with other presenting mental health problems.

Where the difficulties are beyond age -appropriate mood variation.
Where there is a significant impact on daily living e.g. sleeping, eating and/or school attendance.
Where there is positive family history of mental illness or suicidal ideation.

Post Traumatic Stress Disorder

- Symptoms occurring more than 3 months after a recognised traumatic event.
- Intrusion and avoidance of thoughts and memories about the trauma.
- Hyper-vigilance, hyper-arousal and emotional numbing.

Where a child continues to demonstrate hyper-vigilance, avoidance, flashbacks, or a marked increase in unexplained temper tantrums or episodes of other distress 6 months post the trauma.

Obsessive Compulsive Disorder & Tourettes

- Obsessions and/or compulsions with functional impairment.
- Tourettes Syndrome with complex motor and vocal tics, particularly with co-morbidity with OCD and rage.

Deliberate Self Harm

- If accompanied by significant suicidal ideation.
- If presenting with a pattern of emotional deregulation, interpersonal difficulty and maladaptive coping strategies.

Any CYP who reports they have recently taken an overdose should be sent to Derriford Hospital for physical testing. They should not be referred to the Child and Adolescent Mental Health Service.

Attachment Disorders
Antenatal attachment / bonding mother and unborn intervention
Insecure attachment behaviours .

- If presenting with a persistent pattern of abnormal functioning in interpersonal relationships.

Specialist CAMHS will also see individuals with the following presentations if there is evidence of comorbidity with a serious mental health condition.

- Drug and alcohol problems.
- Conduct disorder.
- Children with severe learning disabilities.
- Obesity.
- Enuresis/Encopresis.
- Chronic fatigue /somatisation syndrome.

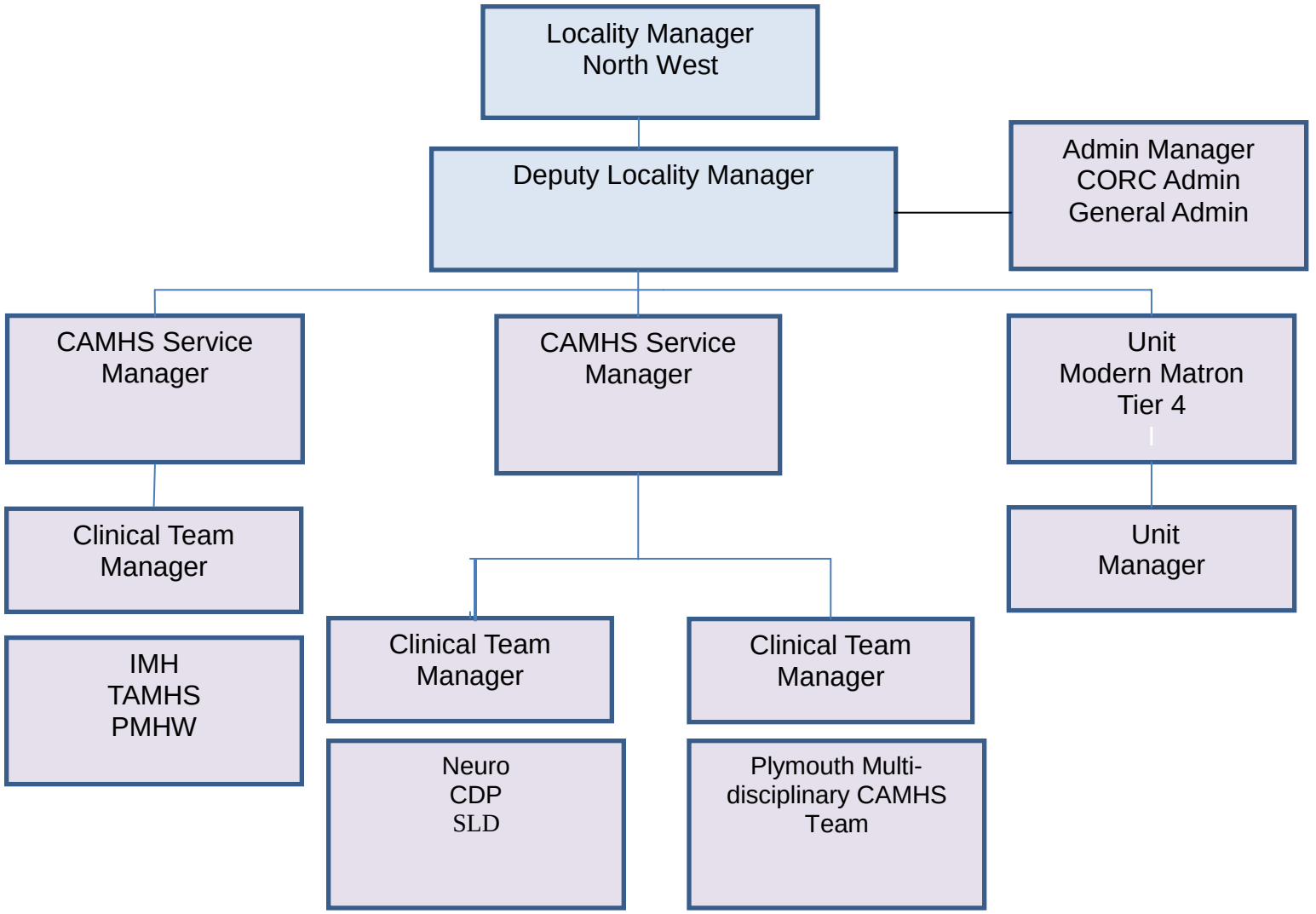
Specialist CAMHS Services in Plymouth is part of a wider network of service provision to support CYP who have emotional, behavioural and mental health difficulties. The provision of services ranges from prevention to in-patient care.

What the CAMHS service does not accept:

- Referrals about apparent mild or transient concerns.
- Referrals requiring court reports or consultation for civil proceedings (e.g. custody issues) (Court proceeding will however not affect eligibility for a service for a child who normally qualifies for help by our service).
- Referrals for school based problems without mental health or family based issues.
- Referrals where social and environmental factors dominate without any mental health or psychological needs.
- Referrals where there are current child protection concerns under investigation, or pending the outcome of legal proceedings (unless the mental health needs of the child/ young person are paramount).
- Severe behavioural disturbance or conduct disorder, in the absence of a treatable psychiatric disorder.
- Moderate to severe learning difficulties, in the absence of a primary diagnosis of mental health difficulties.
- Autism spectrum disorders, in the absence of a primary diagnosis of mental health difficulties.
- A primary diagnosis of substance misuse in the absence of severe and acute mental health difficulties.

Signposting – If not appropriate for CAMHS
Jeremiah's Journey – 01752 424348
NSPCC – 0808 800 5000
Eklipse Counselling – 07891028960
Twelve's Company -08458 12 12 12
Harbour Young People's Service – 01752 434 295
The Zone Icebreak – 01752 206626
Communication and Interaction Team – 01752 308751
Child Development Centre – 0845 155 8155
Plymouth City Council Social Care – 01752 308600
MAST Team – 01752 307761
Family Matters – 01752 606826
Strengthening Families – 01752 258933
Plymouth Parent Partnership – 01752 258933
Eating Disorder Service (17 and 6 months up) – 01752 228027
Streetwise – 01752 308730

CAMHS Management Structure - September 2014



Devon Referral Support Services

Children & Adolescent Mental Health

The Team

DRSS Business Manager	Steve Matson	01752 307751
Operational Support Manager	Naomi Maddick	01752 398748
Team Leader	Sarah Blackmore	01752 398667
Assistant Team Leader	Lucy Cartwright	01752 398700
CAMHS Lead Patient Choice Co-ordinator	Donna Friend	01752 398805 *(Wed, Thurs, Fri)*
CAMHS Patient Choice Co-ordinator	Angela Newman	01752 398742
CAMHS Patient Choice Co-ordinator	Joanna Bennetts	01752 398813
CAMHS Patient Choice Co-ordinator	Fiona Cartlidge	01752 398992

Contact us

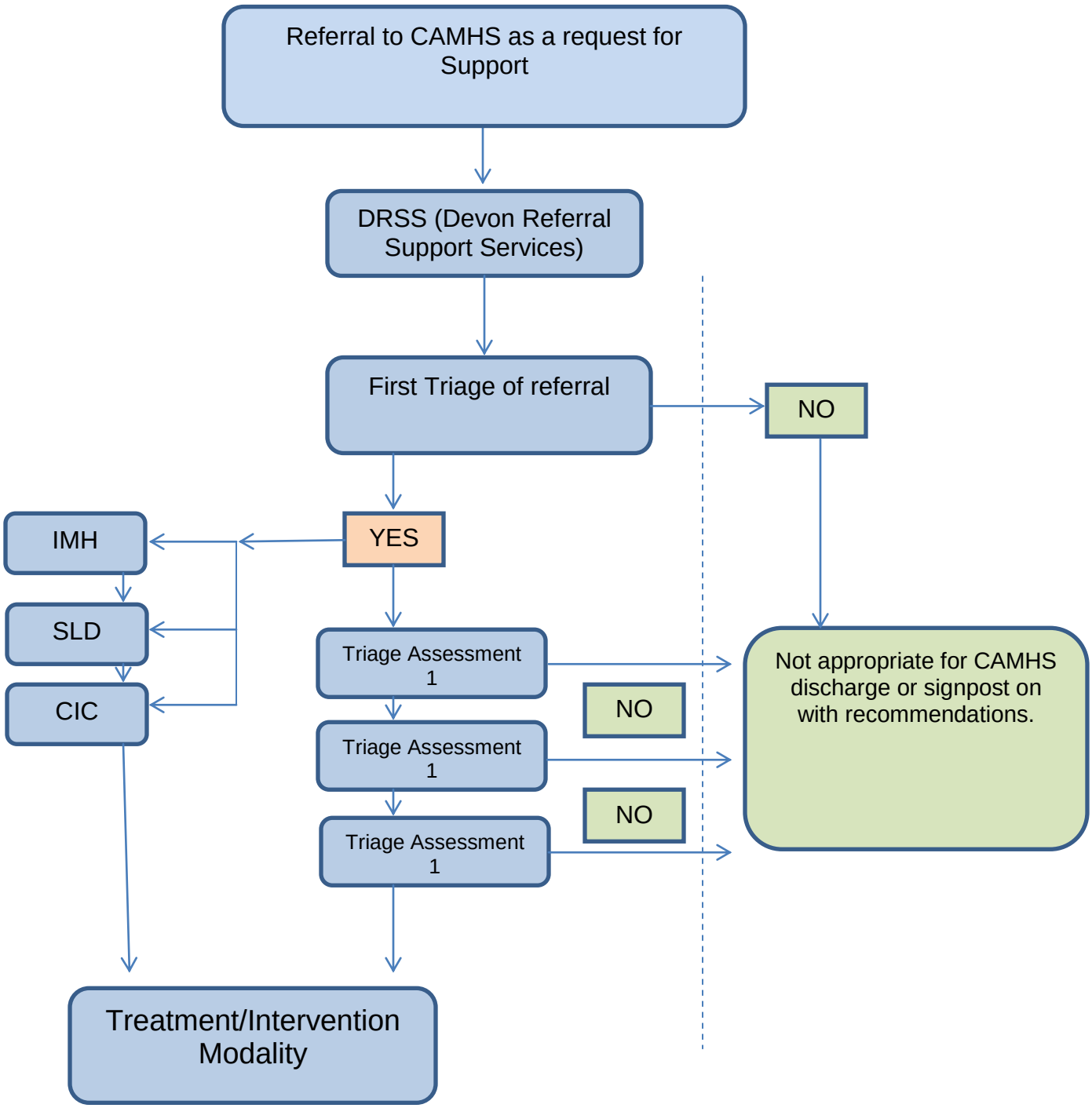
Office hours **Monday - Friday, 08:30 - 17:00**
For urgent referrals outside of these hours, please contact the Outreach Team on **01752 435122**

All enquiries: **01752 398 992**
Calls from a landline are charged at the usual local rate; however calls made from a mobile phone may cost significantly more

Email: **crt.plymouth@nhs.net**
To maintain patient confidentiality, please ensure that you are using a secure N3 connection prior to sending any patient information

Devon Referral Support Service
Ground Floor Windsor House
Tavistock Road
Plymouth
PL6 5UF

Triage Pathway



Appendix E

Glossary of terms/abbreviations

PMDT	Plymouth Multi-Disciplinary Team
CAMHS	Child and Adolescent Mental Health Services
DOH	Department of Health www.dh.gov.uk
HAS	Health Advisory Service
DFES	Department of Educational and Skills – The Department of Education was formed on 12 May 2010 and is responsible for education and children's services
EMDR	Eye Movement Desensitisation and reprocessing. Eye movement desensitization and reprocessing (EMDR) is a form of psychotherapy that was developed to resolve symptoms resulting from disturbing and unresolved life experiences.
ADOS	Autism Diagnostic Observation Schedule The Autism Diagnostic Observation Schedule is the gold standard instrument for diagnosing and assessing Autism.
ADI	Autism Diagnostic Interview
3DI	Developmental, Dimensional and Diagnostic Interview (3DI)
DISCO	Diagnostic Interview Social and Communication Disorders
ADHD	Attention Deficit Hyperactive Disorder
ASD	Autistic Spectrum Disorder
COT	CAMHS outreach team
NICE	National Institute of health and Clinical Excellence **NICE** is an independent organisation responsible for providing national

	guidance on promoting good health and preventing and treating ill health. www.nice.org.uk
PALS	Patient Advice and Liaison Service The **Patient Advice and Liaison Service**, known as PALS, has been introduced to ensure that the NHS listens to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. www.pals.nhs.uk
SDQ	Strengths and Difficulties Questionnaire The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists www.sdqinfo.com
CGAS	Children's Global Assessment Scale The Children's Global Assessment Scale (CGAS) is a numeric scale (1 through 100) used by mental health clinicians and doctors to rate the general functioning of children under the age of 18. www.cgas.co.uk
HoNos Ca	Health of the Nation Outcome Scales For Children and Adolescents HoNOSCA is a routine outcome measurement tool that assesses the behaviors', impairments, symptoms, and social functioning of children and adolescents with mental health problems.
CYPP	Children and Young Peoples Plan The Children and Young People's Partnership is a group of organisations working together to improve the lives of children and young people www.dcsf.gov.uk/everychildmatters/strategy/managersandleaders/planningandcommissioning/cypp/cypp
CAF	Common Assessment Framework The Common Assessment Framework (**CAF**) is a standardised approach to conducting assessments of children's additional needs and deciding how they should be met www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/caframework/

Appendix F

Children's Day Programme

Child and Adolescent Mental Health Service

RESTRICTIVE INTERVENTION REDUCTION PROGRAMME

This policy was developed between **August - October 2014** and follows guidance from the Department of Health, Mental Health Act Code of Policy, Department for Education (DFE) and the policy used by the Alternative Complimentary Education Service (ACE)

Persons responsible: All staff

Date adopted by the Management Committee:

Policy review This policy document will be reviewed by Dr Seb Rotheray and Laura Hernandez in January 2015 under the supervision of Dr Sarah Huline-Dickens, Consultant Child and Adolescent Psychiatrist.

The document was circulated to the following relevant stakeholders for feedback: Nicky Arthurs, Michelle Smith, Tracy Clasby, Graham Carr, Kirsty Spencer and Ian Stevenson. Written feedback was received and the document was amended where necessary.

Introduction

This policy provides a guideline for the assessment and management of disturbed behaviour in children attending the Children's Day Programme (CDP). Our aim in the day programme is to provide a positive and therapeutic culture for all children which focusses on preventing behavioural disturbances through early recognition and de-escalation.

The policy is to be used in conjunction with pre-existing guidelines on restraint and management of aggression produced by Livewell Southwest. The value of this document is that it addresses issues specific to the Children's Day Programme at the Terraces.

Background

This policy is primarily based on guidance from the Department of Health's new Mental Health Act (1983) Code Of Practice (currently in draft form, published 7th July 2014 – the Final Code of Practice is to be issued April 2015). It is particularly based on Chapter 26 'Safe and therapeutic responses to disturbed behaviour'. This also specifically provides guidance on the needs of children and young people.

The draft Code of Practice requires that the organisation has policies in place which provides guidance for the day to day operation of services. These include those listed below:

1) Individualised assessments of risks and need for support
2) The use of behaviour support plans (as defined in paragraph 26.13)
3) How restrictive interventions should be implemented in particular, an assessment of their potential to cause harm to the physical, emotional and psychological wellbeing of patients and how LSW providers will take account of a patient's individual vulnerabilities to harm (such as unique needs associated with physical/emotional immaturity, older age, disability, poor physical health, past history of traumatic abuse etc.)
4) How restrictive interventions which are used by the LSW (enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion and/or long term segregation), should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention (see paragraphs 26.62 – 26.136)
5) Local recording and reporting mechanisms around the use of restrictive interventions
6) Post-incident analysis/debrief (see paragraphs 26.143 – 26.147), and
7) Workforce development, including training requirements relating to the application of restrictive interventions (see paragraphs 26.150 – 26.152).

This document will address each of these policy requirements in turn.

1) Individualised assessments of risks and need for support

- Each child attending the Children's Day Programme (CDP) will on assessment have a CPA risk assessment form completed by the clinician. This includes a specific question about the risk of aggressive behaviour. Information provided by the school must also be included as part of the assessment.
- Children coming to the Day Programme are likely to be at risk of demonstrating aggressive behaviour and so require a specific Behaviour Support Plan. This will be developed at the initial assessment appointment between the clinician, patient and guardian.

2) Use of Behaviour Support Plans

- The behaviour support plan should be completed at initial assessment collaboratively with the patient and their guardian (see proforma below). This will then be uploaded to the electronic patient record (System One).
- A behaviour support plan enables therapeutic responses to a patient. It is based on an understanding of a patient's needs and includes circumstances that are likely to predict behavioural disturbance. Behaviour support plans are individualised care plans and should be made up of primary, secondary and tertiary preventative strategies, as described below.
- Prior to each group of children arriving we will discuss as a team any children with identified behaviour support plans so all team members share the same understanding of how this will be managed.
- If concerns arise then the behaviour support plan can be reviewed and amended at the weekly ward round.
- The proforma for behaviour support plans will be added to SystmOne so that the document can be viewed and updated by all relevant members of

staff.

1) **Primary Preventive Strategies** – These include identifying any possible triggers for disturbed behaviour and making a plan about how to avoid them. The aim is to improve the patient's quality of life and reduce the risk of behavioural disturbance.

2) **Secondary Preventive Strategies** - These focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm. It requires specific de-escalation strategies to be identified to promote relaxation. Working with the family should help to identify appropriate methods.

3) **Tertiary Preventative Strategies** – These provide pre-planned guidance of the use of any restrictive interventions. These should be explicitly discussed with patient's family beforehand and be based on the policy outlined below.

Behaviour Support Plan Proforma

Primary Prevention What are the triggers to aggressive / disturbed behaviour?	How are we going to minimise these?
Secondary Prevention What are the early warning signs of impending behavioural disturbance?	What de-escalation strategies are useful in these situations?
Tertiary Prevention In what circumstances might restrictive intervention be necessary?	What are the indications for use of the Calm Room? When, if ever, would physical restriction be appropriate? What will we do if it is not possible to de-escalate disturbed behaviour?

3) The Use of Restrictive Interventions

Our aim on the CDP is to provide a therapeutic environment and avoid any need to manage disturbed behaviour by physical intervention. However, we recognise that there are two occasions where it may be necessary to use restrictive interventions. These are:

1) To take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken

2) To end or reduce significantly the danger to the patient or others.

If a restrictive intervention is required then we are guided by the following three key principles:

1) It is used for no longer than necessary to prevent harm to the person or to others
2) be a proportionate response to that harm*,
3) It must be the least restrictive option.

If use of restrictive intervention is required staff should consider the following guidance from the Mental Health Act Code of Practice:-

> "Great caution should be exercised in using restrictive interventions on children and young people who are not detained under the Act. If there are indications that the use of restrictive interventions (particularly physical restraint or seclusion) might become necessary, consideration should be given to whether formal detention under the Act is appropriate. A person with parental responsibility can consent to the use of restrictive interventions where a child lacks competence or a young person lacks the capacity to consent, but only if the decision falls within the 'zone of parental control'

Use of Non-Violent Physical Crisis Intervention

Staff working at the Terraces have received bespoke raining in non-violent crisis intervention from Kym Shorthouse, training advisor for Livewell Southwest. This takes into consideration the environment, the age of the service users, and the capabilities of the staff members. It is guided by the JAPAN principles (see Appendix 2)

The training was provided by Livewell Southwest who are governed under General Services Association (GSA). GSA techniques would be taught and are the only techniques that can be used on the unit. With this in mind any outside agencies must not use any techniques they may have been taught by a different governing body. The future plan would be for all new staff or staff who couldn't make the first session to book onto a 3 day course and attend the first 4 hours of day 1.

It was agreed the training would not include any form of floor restraint. Techniques that were taught included low-level holds, walking holds, and seated restraint including chairs and the beanbag. Kym Shorthouse recommended a company from which to purchase a new beanbag. The beanbag should be treated as Personal Protective Equipment (PPE) and wiped down after every use. It must be checked on a weekly basis to ensure there are no rips/tears and to ensure it is full (to check this when the patient sits on the beanbag their backside should not touch the floor). Service users must not be left alone in the beanbag.

It was also agreed should an incident occur and it is considered too risky to intervene staff are to have a protocol to follow.

Other safety points for restraint:

- Restraint must be used as a last resort when all other methods have been exhausted.
- Restraint must be the least restrictive option and used for the least amount of time.
- Each time restraint is used it must be documented in the service users notes as well as on an incident form within 24 hours – the incident form must state who was involved, what happened, why restraint was used, what holds were used and the length of time the restraint lasted.
- Both the staff, patient, and any witnesses must be de-briefed following an incident and this is to be documented.
- Under no circumstances must the deliberate use of pain be used.
- Restraint must not be used as a punishment.
- At no time should pressure be put on or around the neck, chest or back of the service user as this restricts breathing.
- All staff involved or likely to be involved in restraint must be up-to-date with their training in The Mental Capacity Act and Deprivation of Liberty Safeguards.
- Restraint training must be updated on a 12 monthly basis.
- All staff on The Terraces must have Breakaway and Conflict Resolution Training.

The bespoke package taught to the staff by Kym Shorthouse is to only be used on The Terraces and nowhere else. If staff are required to use restraint on any other ward in the organisation, they must attend and pass a full 3 day course.

Use of Time Out / Calm Room Facility

We have a calm room which may be used as part of a behavioural strategy to limit disturbed behaviour. This room may be used in the following circumstances

- preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops
- asking them to leave an activity and return when they feel ready to be involved and stop the behaviour
- or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time

The calm room cannot be used as a seclusion room*. Patients should always be accompanied by a member of staff. Under no circumstances can a patient be shut into the calm room. However, if the patient is highly agitated and there is a need to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken or to end or reduce significantly the danger to the patient or others then it may be necessary to physically restrain the child.

We cannot forcibly prevent the patient from leaving the calm room unless there is specific indication for a restrictive intervention as described in section 3.

*Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving. We do not have the required facilities to seclude patients at the Terraces.

Disturbed Behaviour That Is Not Successfully De-Escalated

If attempts to manage disturbed behaviour using the above described de-escalation policies have not been successful then staff will be required to contact the patient's guardian to request that they come to collect them.

Staff and guardians must be aware of the following guidance from the Mental Health Act

- Parental consent cannot be used to authorise the use of restrictive interventions that deprive the child or young person of their liberty. This is particularly likely to be the risk with the proposed use of physical restraint, mechanical restraint, rapid tranquilisation or seclusion.

- For young people aged 16 or 17 who are not detained under the Act and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests may be authorised under the MCA, provided that they meet the requirements in section 6 of the MCA and do not amount to a deprivation of liberty (see paragraph 26.47).

- Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will depend among other things upon the urgency and gravity of what is required. Whilst this might allow action to be taken to say prevent a child from harming him/herself it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

4) Recording and reporting mechanisms around the use of disturbed behaviour / restrictive interventions

All incidents requiring Restrictive Physical Interventions should be recorded. Records are necessary to confirm that good practice has been observed and in extreme circumstances to provide legal justification for staff actions. This should be written into the patient record on System One and in addition an incident form should be completed.

Incidents must be written up as soon as possible as delay can mean that memories diminish. Incidents need to be reported within 24 hours unless there are extenuating circumstances. Facts should be recorded chronologically, who, when, where. Staff need to be objective, brief and ensure the information is complete and accurate.

The records should include details of any injuries to staff or children, the duration and

effectiveness of the intervention and details of other staff and children involved. This could be direct involvement or as witnesses and the reason for intervention and de-escalation techniques should also be recorded.

Documentation is critical to assess what has taken place and look for ways to prevent or minimise future occurrences. This process can improve the safety of everyone who may be involved in crisis incidents.

5) Post-incident analysis/debrief

- A multi-disciplinary team review / debrief between all involved parties should take place at the next weekly ward round. This should involve the patient if feasible and must involve the guardian.
- Patients' behaviour support plans should be updated as necessary and any specific requests from the patient considered
- Patients / Guardians should be advised of how to formally raise a concern and independent advocacy service, information about this including relevant leaflets and contact numbers should be provided at the initial assessment appointment.

6) Workforce development, including training requirements relating to the application of restrictive interventions

All staff working on the children's day programme are required to be familiar with this 'Restrictive Intervention Reduction Programme' and to have completed the mandatory two day CPI training.

Compliance of all staff members with these training requirements is checked at 3 monthly Clinical Governance meetings.

Appendix

1. Reasonable force – DFE Guidance

The term 'reasonable force' covers the broad range of actions used by most staff on the CDP at some time that involve a degree of physical contact with children / young people. Force is usually used either to control or restrain. This can range from guiding a child to safety by the arm through to more extreme circumstances such as breaking up a fight or where a child needs to be restrained to prevent violence or injury.

'Reasonable in the circumstances' means using no more force than is needed. Control means either passive physical contact, such as standing between children or blocking child's path, or active physical contact such as leading a child by the arm out of a classroom.

Restraint means to hold back physically or to bring a child under control. It is typically used in more extreme circumstances, for example when two children are fighting and refuse to separate without physical intervention. School staff should always try to avoid acting in a way that might cause injury, but in extreme cases it may not always be possible to avoid injuring the child.

All members of CDP staff have a legal power to use reasonable force. This power applies to any member of staff at the CDP. Any volunteers helping run the CDP programme should not be involved in restrictive intervention. Students working with the programme should only be involved in physical restraint if they have received the appropriate training.

Reasonable force can be used to prevent children from hurting themselves or others, from damaging property or from causing disorder. At the CDP, force is used for two main purposes – to control children or to restrain them.

The decision on whether or not to physically intervene is down to the professional judgement of the staff member concerned and should always depend on the individual circumstances. The following list is not exhaustive but provides some examples of situations where reasonable force can and cannot be used.

Schools can use reasonable force to:

- remove disruptive children from the classroom or other rooms where they have refused to follow an instruction to do so;
- prevent a child leaving the classroom where allowing the child to leave would risk their safety or lead to behaviour that disrupts others
- prevent a child from attacking a member of staff or another pupil, or to stop a fight
- restrain a child at risk of harming themselves through physical outbursts.

Staff cannot: use force as a punishment – **it is always unlawful to use force as a punishment.**

2. JAPAN Principles

The Legal Use of Force

J = Justify

(How and in what circumstances)

A = Auditable

(How & Where do we audit the use of force)

P = Proportionate

(Considering the amount of force used)

A = Accountable

(How? To Whom? Why?)

N = Necessary

(How?)