POLICY: THE VISITING OF PSYCHIATRIC IN-PATIENTS BY CHILDREN

Camden and Islington NHS
Mental Health NHS Trust

Camden
SOCIAL SERVICES

ISLINGTON

1 *Introduction*

The revised Mental Health Act 1983 Code of Practice, 1, paragraph 26.3, requires hospitals, in consultation with local Social Services Departments, to develop policies on the arrangements for the visiting of patients by children. The combined Health Service 1999/222 and Local Authority (99) 32 Circular, 2, sets out the principles and procedures that should be followed when considering visits by children. The purpose of this policy is to build on these guidelines and outline the principles and processes for child visiting within the Mental Health Services. The Locality Directors will be responsible for the development and monitoring of the policy and the investigation of related complaints through the Locality and Professional Structures. Although the policy is multidisciplinary in nature and requires the commitment of all members of the MDT, Team Managers will be responsible for the day to day implementation of the policy. This policy aims to incorporate the principles of all relevant legislation, including the Human Rights Act, the Mental Health Act and the Children Act. This policy applies to all children up to the age of 18 years.

2 *Principles*

The policy will reflect the following principles:

- The welfare of the child is paramount and must inform all decision making in relation to visits by children to patients on psychiatric in-patient wards.
- The Social Services Children and Family (C&F) Divisions of the Boroughs of Camden and Islington, and the ward Multidisciplinary Team have a shared responsibility for undertaking an assessment of whether a visit can take place in cases where concerns have been raised.
- The C&F Divisions will have sole responsibility for determining what is in the child's best interest.
- A child will only be allowed to visit when it can be demonstrated that this will be safe and will promote the child's best interest.
- The hospital will provide a safe environment for visits to take place in.

3 *Assessment*

In the main, the majority of patients are admitted informally and most visits by children to patients, whether detained or not, are central to the maintenance of good, positive relationships with parents or other relatives in hospital. It is important that consideration for a child's welfare is given as early as possible in the process of admission, and is done in a structured and consistent manner. This process should begin at the point of assessment, and this policy will describe the process for both detained and informal admissions.

4 *Admission under the Mental Health Act (1983)*

4.1 Whenever formal admission is being considered, the needs of, and arrangements for any children in the family, or for whom the patient has parental responsibility, will be considered by the ASW as an integral element within the assessment. This information will be recorded by the ASW on the relevant form, and in the event of admission, communicated to the ward staff and a copy included in the medical notes. As part of the assessment, the ASW will give consideration to the welfare of any child involved. If there are any concerns about the child's safety and/or welfare, the ASW will alert C&F Divisions of Camden and Islington Social Services or the Out of Hours Duty Teams.

4.2 In circumstances where there are other person(s) who are parents or have parental responsibility for the children of the patient, the ASW will, where appropriate, provide the hospital with information about any views they might have. ASWs will be sensitive to situations where the relationship between parents has broken down so that any decision about child visiting is not used inappropriately in residence or contact disputes.

5 *Informal Admission*

When a patient is being assessed and considered for an informal admission, the assessing professional(s) will give consideration to the needs of and

arrangements for children who may wish to visit the patient. This information will be clearly recorded and will be accessible to other colleagues. The admitting professional(s) will alert their colleagues in Children and Family Divisions if they have any concerns about child care arrangements for dependent children of the patient. Where possible, and if appropriate to do so, the admitting professional(s) will seek the views of other persons) with parental responsibility for the patient's children. If the patient is not known to Services, the admitting professional will, where possible, contact the relevant local CMHT to establish if the local C&F Divisions are, or have been involved with the patient. This information will be a core feature of the hand over process to ward staff.

6 *Multi-Disciplinary Ward Team*

6.1 In the vast majority of cases the MDT will be able to decide if a visit can go ahead. However, in circumstances where the MDT feels unable to make a decision, the MDT needs to be able to gain access to specialist assessment from the local C&F Division. These arrangements need to be flexible enough to ensure that decisions are taken without undue delay or distress to the child, patient and carer. In circumstances where the child's care is already allocated to the C&F Team, they will remain involved, be accessible to the MDT and responsible for the welfare of the child.

6.2 On admission, or at the earliest opportunity a risk assessment with regard to the child visiting will be undertaken by the MDT in order to establish any likely risk that the patient and/or ward environment may present to the child. This will occur as a matter of routine and before requests for a visit are made.

6.3 Within the risk assessment specific consideration will be given to:

- The patient's history and family situation.
- The patient's current mental state.
- The child's response to the patient and his/her mental illness.
- The wishes and feelings of the child.
- The age and overall emotional needs of the child.
- Consideration of the child's best interests.
- The views of parents, carers and those with parental responsibility.
- The usual level of contact between adult and child, and the nature of the relationship between parent and child. This relationship must be promoted if it is in the best interests of the child.
- The nature of the ward and the patient population as a whole.

6.4 As part of the risk assessment, the MDT will ensure that wherever possible, a current opinion of their needs has been provided by the patient's care co-ordinator, or is available as part of the admission assessment, prior to any decision being made.

6.5 In circumstances where the MDT feels unable to make a decision or requires a more in-depth assessment, they will advise the patient and their family of the rationale for, and process of an assessment. The MDT will then contact the local C&F Division to discuss how to proceed and whether or not the C&F Division needs to carry out an assessment of need. When the C&F Division agrees to undertake an assessment of need, this will be completed within 7 working days. The MDT will also inform the patient's care co-ordinator. The assessment will give specific consideration to the child's best interests, whether a visit should be supervised and the arrangements for travel. The C&F Division will communicate the outcome of its assessment to the ward in the first place and then to the patient's family, who will then be asked to contact the ward to arrange a visit. If the C& F assessment is that the visit should not go ahead, they will decide if a reassessment is necessary. All requests for assessment made by the MDT and outcomes of assessments by C& F must be confirmed in writing. (Local contact arrangements to be described in more depth on a flow chart).

6.6 Decisions to refuse visits will only be taken when it is believed that the welfare of the child would be harmed by a visit taking place. If the C&F Division has recommended that a visit cannot go ahead, they will communicate this to the child and patient. Once the C&F Division has made this recommendation it cannot

be overridden by the MDT. In circumstances where the MDT has made the decision to refuse a visit, the Consultant, or someone delegated by them, will communicate the decision to the patient and child, on behalf of the MDT. All decisions will be communicated verbally and in writing, in a manner that is appropriate to the age and understanding of the child. The decision to refuse a visit will need to be supported by clear evidence and concerns from the risk assessment. The decision and the supporting evidence must be clearly recorded both by the MDT and the C&F Division.

6.7 Where the visit has been declined, the patient and parents can make representation in writing to the Medical Director/Clinical Head of Service and Locality Director for a review of the decision. The Medical Director and Locality Director will communicate their decision to the patient, parents and child within two working days.

6.8 The patient can, if s/he wishes, have access to the independent Advocacy Workers within the Service, in order to assist them with this process. When there has been an assessment by the C & F division they will provide information about how to make a complaint, and / or challenge their recommendation**.**

7 *Arranging a visit*

7.1 The arrangements for a visit will be a feature of the patient's care plan, which will reflect any enhanced level of observation the patient may be on, and additional supervision, which may be required in line with the Observation of Patients at Risk policy. Supervision should be sensitive and balanced between the need for privacy and safety.

7.2 In some cases it may be better for visits to take place off the ward and may require consideration of a detained patient's leave status.

7.3 Ideally, visits will take place during the ward visiting times. However, special arrangements can be made for families to visit outside of these times, and should be done through agreed prior arrangement with the patient's primary nurse or Ward Manager.

7.4 Visits will take place in an environment which is child friendly and available for the duration of the visit. The child will not have access to other parts of the ward.

7.5 Children will be able to enter the ward either independently or in the company of an adult responsible for their care, and this will be determined at the assessment stage. The safety of the child whilst on the ward is the shared responsibility of the adult accompanying the child, when there is one, and the hospital staff.

7.6 If more than one family is visiting at any one time, the shift co-ordinator will discuss the visiting arrangements with the responsible adult and arrange a suitable room for the visit. Priority should be given to patients who are detained under the Mental Health Act, and whose ability to leave the ward may be restricted. Suitable rooms may include interview rooms, and very careful consideration should be given to using single bedrooms. Visits will not take place in patient dormitories.

7.7 The accompanying adult or the ward staff should feedback any concerns they may have had about the visit to the patient's primary nurse, for discussion at the next clinical review of the patient.

8 *Unexpected visits*

8.1 Arrangements will need to allow for unexpected visits by children, where no previous decision has been taken.

8.2 In circumstances where the MDT is awaiting the outcome of an assessment from the C&F Division, the visit should not be agreed until the assessment has been completed, and the reason for this should be explained to the patient and child, and documented in the patient's notes.

8.3 In all other circumstances the MDT must make an initial assessment and decision in line with 6.3 and 6.4 of this policy. The assessment will be carried out by at least a Senior Ward Nurse and Senior House Officer. If the decision is to allow the visit, consideration will be given, as part of the assessment, to whether a responsible adult and/or a member of the MDT should

appropriately supervise the visit, in order to safeguard the child's welfare. If the decision is not to allow the visit, this must be clearly explained to both the child and the patient. In all circumstances, the assessment and its outcome will be clearly documented in the patient's notes. If the visit does not go ahead, arrangements for the child visiting will be reassessed at the earliest opportunity as per section 4 of this policy.

9 *Section 17 Leave*

Staff should be aware of the child protection and child welfare issues when granting leave of absence under Section 17 of the Mental Health Act, and the conditions of a patient's leave will be clearly recorded on the Section 17 form. Where there are likely to be child welfare issues in connection with a patient's leave, there must be prior communication with the Social Services C&F Division responsible.

10 *The Care Programme Approach*

Aftercare arrangements under the Care Programme Approach should be consistent with this policy, and acknowledge any continuing needs of the child as well as the adult.

11 *Training and Education*

All staff should recognise the child's need to maintain good and positive relationships with parents and other adults with whom they have developed appropriate attachments. This will require all staff involved in specialist mental health services to develop and build on the appropriate attitudes, knowledge and skills, particularly in determining what is in the best interests of the child.

12 *Review*

It is acknowledged that this policy cannot address every eventuality, and that the needs of the individual child and patient, judgement and experience of professionals will influence its application. The policy will be reviewed within twelve months and in the light of experience.

13 *Audit*

In order to support the review of the policy, an audit will be designed to consider the number of occasions when a request for C&F assessment has been made the timescale for assessment, outcome of assessment, number of unannounced visits and outcome and MDT decisions to refuse visits. The audit will take place in one Locality; this is in recognition of the potential difficulties in co-ordinating an audit across all four localities.

References

1 Code of Practice, Mental Health Act 1983.

2 Health Service Circular/Local Authority Circular HSC 1999/222: LAC (99) 32.

3 Human Rights Act 2000

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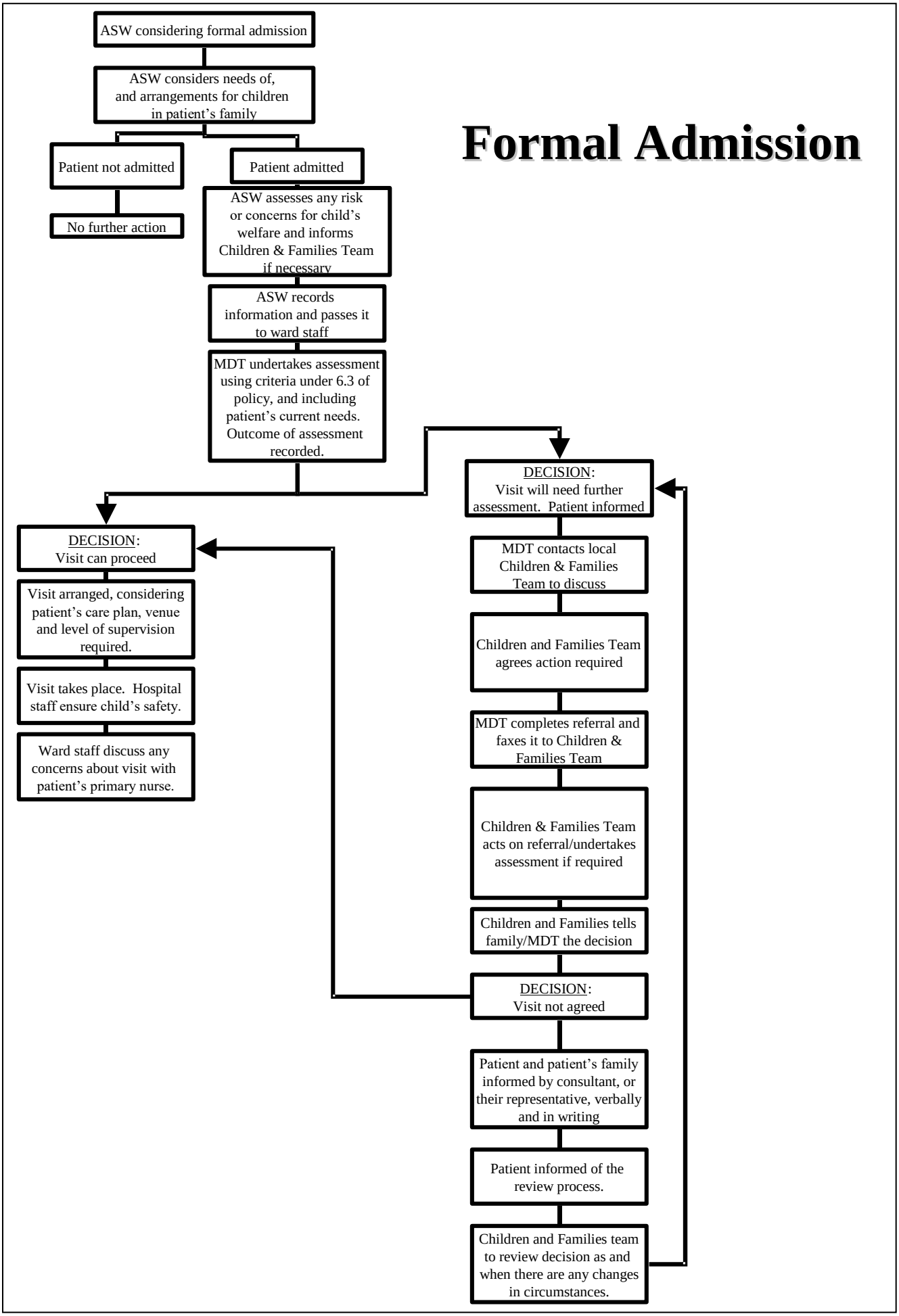
Formal Admission



Informal Admission