

## Referral for Access Assessment into Inpatient Services for Children & Young People

### PART A: ALL FIELDS TO BE COMPLETED BY CAMHS COMMUNITY CLINICIAN, EXISTING INPATIENT SERVICE or ADULT CRISIS TEAM

Referral Type:	Unplanned	Routine/planned
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#### Please indicate which type of service may be required:

Delete as appropriate: **Not known/General Acute/ PICU/Eating Disorder/Low secure/Medium secure/ Learning Disability**

#### Young Person's current location:

Delete as appropriate: **Home/CAMHS Inpatient Unit /Paediatrics /A&E/Place of Safety 136/Section 136 Police Station/ Secure Children's Home/Other :**  
**Postcode: (required)**

#### The existing clinical team will retain responsibility for patient care until an admission into a CAMHS inpatient placement

**Is there any restriction on sharing information?** If so please give details: Yes  No

Details:

#### 1. Personal Details

Full name:	Previous surnames:	
Address:	Date of Birth:	
	NHS No:	
	Gender: <b>Male / Female</b>	
	Religion:	
	Ethnicity:	
Postcode:	First language:	
Special consideration for communications:		
CCG:		
GP name and address:		
Parent or guardian name:	Address:	
Does the person above have parental responsibility?		<b>Yes</b> <b>No</b>
Name of person with parental responsibility:		
Contact telephone number:		

Parent or carer if different to above who should be kept informed of young person's care:	Address:
Contact telephone number:	

2. Care & Treatment Review (CTR) – please include any previous CTR reports			
<i>Tick as appropriate</i>		Yes	No
Does the patient have a formal evidenced diagnosis of Learning Disability / ASD or Autism? (If no, continue to 3. Safeguarding)		<input type="checkbox"/>	<input type="checkbox"/>
Has a Community CTR been completed?		<input type="checkbox"/>	<input type="checkbox"/>
Did the Community CTR support the referral?		<input type="checkbox"/>	<input type="checkbox"/>
Date of Community CTR			
Name of Contact			
Email/telephone			
Any relevant information:			
Has a Blue Light CTR been completed?		<input type="checkbox"/>	<input type="checkbox"/>
Date of Blue Light CTR			
Name of Contact			
Email/telephone			
Any relevant information:			

3. Safeguarding		
If under 16 years, is the young person sexually active?	Yes	No
Likely to be pregnant?	Yes	No
If yes, EDD:		
Midwife:	Consultant:	
Hospital details:		
If there are safeguarding concerns around this young person, detail here:		

4. Legal Status at time of Referral		
<b>Is the Child:</b> <i>tick as appropriate</i>	Yes	No
Currently detained under the Mental Health Act? <i>If yes, what identify below:</i>	<input type="checkbox"/>	<input type="checkbox"/>
Under Section 136	<input type="checkbox"/>	<input type="checkbox"/>
Living with parent/carer with parental responsibility	<input type="checkbox"/>	<input type="checkbox"/>
Voluntarily accommodated by the Local Authority (s20)	<input type="checkbox"/>	<input type="checkbox"/>
Subject to Care Order (s 31)	<input type="checkbox"/>	<input type="checkbox"/>
<b>If s20 or s31, are they placed in:</b> <i>tick as appropriate</i>		
Foster Care	<input type="checkbox"/>	<input type="checkbox"/>
Residential Care	<input type="checkbox"/>	<input type="checkbox"/>
With Parents	<input type="checkbox"/>	<input type="checkbox"/>
<b>Is the child subject of:</b>		
Child in need plan	<input type="checkbox"/>	<input type="checkbox"/>
Child Protection Plan	<input type="checkbox"/>	<input type="checkbox"/>
Child in Care (LAC) Plan	<input type="checkbox"/>	<input type="checkbox"/>
Any other legal status (Children Act; Criminal Justice)?	<input type="checkbox"/>	<input type="checkbox"/>
Is there an Education, Health and Care plan? <i>(Please provide details)</i>	<input type="checkbox"/>	<input type="checkbox"/>

5. Reason for Referral for Access Assessment and admission	
<b>Rationale for referral:</b> (Detail KEY bullet point information why an inpatient admission is necessary and the care and treatment that cannot be effectively delivered in the community)	<ul style="list-style-type: none"> <li>•</li> </ul>

6. Aims of the admission	
From the referrer	
From the young person	
From the parent/carer	

7. Consent (also see narrative below this section)			
<i>Tick as appropriate</i>		Yes	No
Has the patient got capacity to consent to this admission		<input type="checkbox"/>	<input type="checkbox"/>
Has the patient given consent to admission (see note below)		<input type="checkbox"/>	<input type="checkbox"/>
Has the CAMHS Community Team received consent from the young person, their parent(s)/carer to be assessed by the Access Assessor?		<input type="checkbox"/>	<input type="checkbox"/>
Consent Received By: (Print name)		Signature:	
Date:		Time:	
The young person is willing to share/receive any relevant information with other health care professionals and agencies, such as school/Social Services?		<input type="checkbox"/>	<input type="checkbox"/>
Date:		Time:	
If the child is under 16 year of age the parent/carer consent to transfer of referral information to CAMHS or other partnership agencies if assessed as more appropriate for their needs?		<input type="checkbox"/>	<input type="checkbox"/>
If the young person is over 16 years of age, they consent to transfer of referral information to CAMHS or other partnership agency if assessed as more appropriate for their needs?		<input type="checkbox"/>	<input type="checkbox"/>
Has the patient and family been advised that this necessary information will be shared with NHS England to ensure that appropriate services can be delivered.		<input type="checkbox"/>	<input type="checkbox"/>

### Consent

The young person's capacity to consent to be admitted into hospital must be assessed. For the young person (or parent / carer) to make an informed decision; information, where possible, should be explained in terms of expectations of the admitting hospital re engagement, observation practices, treatment programme etc.

Considerations also to take into account:

1. Competent child or young person can consent to admission
2. Parent can consent on behalf of a child who is not competent and falls within zone of parental control
3. Over 16 who lacks capacity and where admission does not involve deprivation of liberty can be under provisions of Mental Capacity Act.

4. If a competent child/young person refuses or there are reasons not to rely on consent or if parental consent not applicable or reasons not to rely on parental consent then consider admission under the Mental Health Act 1983 (NB: only young people detained under the Mental Health Act may be considered for Psychiatric Intensive Care Units (PICU), low or medium secure units).

8. CAMHS Community Assessment	
Date of Clinical Assessment:	Time of Assessment:
Name and job title of Referrer:	
Name of consultant endorsing referral:	
Referring Team and NHS Trust:	
Signature of Referrer:	Contact Tel No:

9. Name of NHS England CAMHS Case Manager	
Name:	Region:
Email:	Tel:

10. Previous referrals for CAMHS Inpatient Access Assessments – tick where appropriate	
Previous CAMHS Inpatient admissions <input type="checkbox"/>	Previous Inpatient Access Assessments declined <input type="checkbox"/>
Name of Unit and Date:	Dates:

11. Details of person completing this form – please note that <u>section 20</u> must be signed by the referring clinician as well.	
Full Name (printed):	NHS Trust name:
Date:	Job Title:
Email:	Tel:

### Important Notes

Please ensure that the NHS England CAMHS Case Manager receives a copy of Form 1 at the **same time** as the local Access Assessor for **all** referrals. Patients who may need out of area placements will need to be discussed and approved by the CAMHS Case Manager to ensure there are no delays in admission.

Further details on the referral process can be found in the NHS England Operating Handbook, which can be obtained from your CAMHS Case Manager.

PART A: Must be completed for all referrals and less than 7 days old. Inpatient units prefer PART B of this form to be completed, although supporting clinical documentation can be submitted with PART A, it must include the information from all the sections covered below. If not please COMPLETE PART B. PLEASE CHECK that all sections are covered before sending the referral.

**Lack or out of date information and incomplete sections can result in a delay in admission due to the inpatient unit not having the necessary and relevant information to make clinical decision.**

**PART B:**

**12. Presenting Problem/ Mental State Examination/Current medication**

Current presentation: (include duration, frequency and severity of triggers, Maintaining factors, Coping mechanisms, Current resources)

Date of latest Mental State Exam:	Undertaken by:
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**History of presenting problem/s:** (Precipitating factors, Previous life events/trauma, History of mental health difficulties, What has been tried; what has worked/not worked)

**Appearance and behaviour:**

**Speech:** (rate; intonation; volume; pitch; use of language; disorders of speech)

**Mood and affect:** (subjective and objective)

**Thought processes and content:** (Formal thought disorder; delusions; preoccupations; obsessions; self-image)

**Perceptions:** (hallucinations; derealisation/dissociation)

**Cognitions:** (Orientation to time; place; person; age; attention; concentration)

**Insight:** (Understanding of difficulties and motivation to change)

**Most Recent outcome measurements**

HoNOSCA  CGAS  SDQ  Other

**13. Developmental History**

<b>Is there a diagnosis available:</b> (e.g. ASD or other disorder)	Yes <input type="checkbox"/> No <input type="checkbox"/>
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Details:

**Difficulties during pregnancy/birth:**

**Key development milestones:**

14. Family Situation				
Composition of household and significant adults:				
Family history of mental health difficulties, Physical illness:				
Current/historical bullying:				
History of domestic violence:				
Siblings				
Name:	DoB:	School:	Carer & Address:	GP:

15. Risk Factors	
Date of recent risk assessment:	Completed by:
Details of recent risk assessment: (attach a copy if available)	
Risk to self? (including history of self-harm/suicidal ideation)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Risk of absconding?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Risk to others?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Self-neglect?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Exploitation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Other?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
Physical Health e.g. Diabetes/Allergies? if Yes, complete section 15	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sensory impairment: if Yes, please complete details in additional information	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eating disorder diagnosis? if Yes, complete section 16	Yes <input type="checkbox"/> No <input type="checkbox"/>
Forensic History? if Yes, complete section 17	Yes <input type="checkbox"/> No <input type="checkbox"/>
Drug/Alcohol use? if Yes, complete section 18	Yes <input type="checkbox"/> No <input type="checkbox"/>
Additional important information?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	

### 15. Risk Factors

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### 16. Education

Current School:	Previous School:	Preferred Contact Person:	Current School Year:
<b>Academic performance:</b>			
<b>Learning difficulties:</b>			
<b>Any other agencies involved? If so, who:</b>			

### 17. Hobbies/Skills/Strengths

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### 18. Previous Psychiatric History

<b>Previous psychiatric history:</b>
<b>Details of Care Coordinator:</b>
<b>Interventions tried so far:</b>
<b>Input from other Health Professionals or agencies:</b>

### 19. Physical Health

<b>Details of any physical health conditions, disabilities and known allergies:</b> (include any known future appointments or physical investigations)	
<b>Is this young person Deaf, user of British Sign Language (BSL) or person with a hearing impairment?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details:	
<b>Does this young person smoke?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Details: (include amount; frequency; motivation to use/change; effects)	

### 20. Eating disorder

<b>Current and historical difficulties:</b>			
Date of assessment	Weight/Height	BMI	Calorific intake

### 21. Forensic History

<b>Forensic history:</b> (include involvement with Youth Offending Team)

<b>21. Forensic History</b>
<b>Criminal charges:</b>
<b>Court orders:</b>
<b>Court dates:</b>

<b>22. Drugs/Alcohol</b>
<b>Drugs: Past and current use</b> (include amount; frequency; motivation to use/change; effects)
<b>Alcohol: Past and current use</b> (include amount; frequency; motivation to use/change; effects)

<b>23. Important Contacts Sheet</b>
<b>PLEASE COMPLETE TO ENSURE THAT THE APPROPRIATE PEOPLE ARE INFORMED OF THIS YOUNG PERSON'S CASE AND INVITED TO MEETINGS SUCH AS CPA'S.</b>

<b>Primary community contact or care coordinator</b>	<b>Social work contact</b>
Name: Job Title: Organisation: Telephone Number: Email Address:	Name: Job Title: Organisation: Telephone Number: Email Address:
<b>Nearest relative (under the MHA) if different from next of kin</b>	<b>Community psychiatrist</b>
Name: Job Title: Organisation: Telephone Number: Email Address:	Name: Job Title: Organisation: Telephone Number: Email Address:
<b>Psychologist</b>	<b>Dietician</b>
Name: Job Title: Organisation: Telephone Number: Email Address:	Name: Job Title: Organisation: Telephone Number: Email Address:
<b>Family Therapy</b>	<b>Other</b>
Name: Job Title: Organisation: Telephone Number: Email Address:	Name: Job Title: Organisation: Telephone Number: Email Address:

<b>24. Signature of referring clinician</b>	
Full Name (printed):	Signature:
Date:	Job Title:
Email:	Tel:



## **Addition information for a Referral for Assessment into Low or Medium Secure Inpatient Service for Children & Young People**

The additional information only needs to be completed if a young person requires consideration for a low or medium secure in-patient placement, please follow the steps below:

- The NHS England Referral Form 1 should be sent to the relevant Access Assessor and NHS England CAMHS Case Manager for a local access assessment. Once a Form 2 has been completed a referral to a secure setting can be made
- decide which type of secure setting is required using the guidance on the following page; ensure that it is not a short-term PICU as opposed to a longer-term low or medium secure unit (LSU or MSU) that is required
- if there is uncertainty about whether a low or medium secure placement is needed, contact a senior clinician (preferably at the nearest medium secure unit) in the national Medium Secure network to help clarify this (contact details on p 3 of this appendix)
- once the level of security has been identified:
  - ensure, in the case of a medium secure referral, that the patient's CCG is aware that a referral is being made, and that they will fund the initial assessment; referrals to low secure care do not incur an assessment fee
  - complete the additional information form (pg. 4-6 of this appendix) in relation to issues of risk, youth justice or other statutory status; this information should supplement (and not replace) the standard NHS England in-patient referral form for young people
- In the case of a need for low security, refer to the nearest low secure unit to the young person's home after discussion with the local NHS England CAMHS Case Manager.
- In the case of a need for medium security, refer to the nearest unit within the network (as outlined on page 3 of this appendix); the medium secure units function as a network and all referrals will be considered by all the units within the network once a week or as detailed within the service specification.

**Guidance re decision-making when making a secure adolescent inpatient referral**

Medium Secure Provision	Low Secure provision
<p><b><u>Referral Criteria</u></b></p> <p>The young person is under 18 years of age at the time of referral and within a foreseeable time of admission</p> <p>AND:</p> <p>The young person is liable to be detained under either Part II or Part III of The Mental Health Act 1983</p> <p>AND:</p> <p>The young person presents a significant risk* to others of <i>one or more</i> of the following:</p> <ul style="list-style-type: none"> <li>• Direct serious violence liable to result in injury to people,</li> <li>• Sexually aggressive behaviour</li> <li>• Destructive and potentially life threatening use of fire</li> </ul> <p>AND:</p> <p>There is clear evidence prior to referral that serious consideration (and testing where appropriate) of less secure provision will exceed the ability of available mental health services to meet the needs of the young person.</p> <p><i>* It is not necessary that the referred young person should be facing criminal charges for these risk behaviours, but it is necessary that there should be reliable accounts available of such behaviour.</i></p>	<p><b><u>Referral Criteria</u></b></p> <p>The young person is under 18 years of age at the time of referral</p> <p>AND:</p> <p>The young person is liable to be detained under either Part II or Part III of The Mental Health Act 1983</p> <p>AND:</p> <p>The young person is not safely managed in an open environment and is assessed as having needs than cannot be managed by shorter term admission to a psychiatric intensive care unit (PICU)</p> <p>AND:</p> <p>The young person presents a risk of harm to others; themselves or suffers from a mental disorder that requires inpatient care, specialist risk management procedures, and specialist treatment intervention.</p>

**Important Considerations**

Young people with mental disorder who present a grave danger to the general public (which may include some high risk young people who may have no offending history, as well as those who have been charged with or convicted of specified violent or sexual offences under Schedule 15 of the Criminal Justice Act 2003) should be referred to the medium secure network.

Young people who are directed to conditions of security under a Restriction Order by the Ministry of Justice (s.49 MHA); to include a young person in custody (remand or sentenced) OR have has been sentenced by a Crown Court to a Restriction Order (s.41 MHA) should be referred to the Medium Secure Network.

Young people with brief episodes of disturbed or challenging behavior as a consequence of mental disorder (including neurodevelopmental disorders) are usually most appropriately cared for in PICU.

When uncertain, referring clinicians are encouraged to seek advice regarding whether a young person would be most appropriately referred to low secure or medium secure; this advice can be provided by senior clinicians within the medium secure network (contact details on page 3 below).

The medium secure service is provided through a clinically managed network consisting of six units:

Unit	Provider and contact details	Number of beds	Gender
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<b>Alwood, Newcastle</b>	Northumberland, Tyne and Wear NHS Foundation Trust Tel: 0191 223 2555 Fax: 0191 223 2235	15 mental health 7 learning disability	Mixed
<b>Ardenleigh, Birmingham</b>	Birmingham and Solihull Mental Health NHS Foundation Trust Tel: 0121 678 4602 Fax: 0121 678 4609	18 mental health	Mixed
<b>Bluebird House, Southampton</b>	Southern Health NHS Foundation Trust Tel: 02380 874575 Fax: 02380 874580	20 mental health	Mixed
<b>Malcolm Arnold House, Northampton</b>	St Andrew's Healthcare Tel: 01604 614242 Fax: 01604 614508	20 learning disability	Male only
<b>Gardener Unit, Manchester</b>	Greater Manchester West Mental Health NHS Foundation Trust Tel: 0161 772 3668 Fax: 0161 772 3443	10 mental health	Male only
<b>Wells Unit, West London</b>	West London Mental Health NHS Trust Tel: 020 8483 2244 Fax: 020 8483 2246	10 mental health	Male only

Once a Form 1 and 2 have been completed by the local Access Assessor and discussed with the NHS England CAMHS Case Manager, referrals can be made to the closest unit to the patient's home even if it will not be the admitting unit. All referrals are discussed at a weekly National Referrals Meeting with input from all units (held via videoconference) and a NHS England CAMHS Case Manager when, if appropriate, the referral will be allocated to a specific unit for assessment. This allocation will be made based on available treatment, geography and current capacity to admit.

There is currently a one-off fee for assessment, to be paid by the patient's CCG. All other health costs associated following admission will be met by National NHS England commissioning arrangements. The medium secure service undertaking the assessment will need to seek funding approval from the relevant CCG, but no funding decision should affect the assessment being undertaken.

**The units welcome early discussion of potential referrals, and encourage clinicians to make contact prior to referral.**

**Additional Information Required for Referral to Secure (Low and Medium Secure) Inpatient Services**

25. Further detail of incidents of harm to others	
<b>Date of incident:</b>	<b>Description of incident, including use of weapons, precipitating factors, injuries sustained:</b>

26. Further detail of contact with criminal justice system	
<b>Is the young person currently subject to criminal court proceedings?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details (current charge(s), name of court, date of next court hearing):</b>	
<b>Is the young person currently remanded into youth detention accommodation? (i.e. under section 91(4) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012)</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details (name of custodial establishment, mental health in-reach team contact, date of next court appearance):</b>	
<b>Is the young person currently on bail?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Details (bail conditions, name of police / YOT contact):</b>		
<b>Does the young person have past convictions?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Date of conviction:</b>	<b>Offence details:</b>	<b>Sentence:</b>
<b>Is the young person currently serving a custodial sentence?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details (sentence order, length of sentence, estimated date of release, name of custodial establishment, mental health in-reach team contact):</b>		
<b>Is the young person currently subject to a community sentence?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details (sentence order, length of sentence, estimated end of sentence, name of YOT and YOT officer, licence conditions):</b>		
<b>Is the young person currently subject to MAPPA?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details (level and category, MAPPA contact):</b>		

<b>27. Further detail of social care history</b>	
<b>Is the young person currently a Looked After Child?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is the young person currently subject to a Full Care Order?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is the young person currently subject to a Secure Accommodation Order?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is the young person currently a "ward of the court"</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is the young person detained under the Immigration Act 1971 or section 62 of the Nationality, Immigration and Asylum Act 2002</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Details:</b>	

Placement history:	
Date of placement:	Placement details: