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Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children

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Mental Health Act 1983 Code of Practice: Guidance on the visiting of psychiatric patients by children

1 Summary

This circular provides further guidance to NHS trusts, Health Authorities and Local Social Services (SSDs) on the implementation of the guidance at paragraph 26.3 of the revised Mental Health Act 1983 Code of Practice, published in April 1999, which states that:

"Hospitals should have written policies on the arrangements about the visiting of patients by children, which should be drawn up in consultation with local social services authorities. A visit by a child should only take place following a decision that such a visit would be in the child's best interests. Decisions to allow such visits should be regularly reviewed."

The attached guidance gives details of who should be responsible for the development and implementation of child visiting policies and what principles should be followed when drawing up policies. It emphasises that in the vast majority of cases, the issue of whether a child should visit will be straightforward, and in these cases, policies should aim to encourage and facilitate contacts between children and adults which are considered to be in the child's interest.

The guidance also sets out the steps that should be taken when making a decision to refuse a visit by a child to a detained patient, including the need for arrangements for review and processing complaints.

2 Action

Chief Executives of Trusts, on behalf of the Trust Board should ensure that:

- A child visiting policy is developed in consultation with the local SSD.
- A senior manager is nominated to be responsible for overseeing the child visiting policy, monitoring its operation within the Trust, dealing with complaints and advising the Trust Board about the implementation of the policy.
- Member(s) of senior ward staff are nominated who will have delegated responsibility for ensuring the day to day implementation of the child visiting policy and to support and supervise key workers and other staff.
- All relevant members of staff, including Mental Health Act administrators and clinical staff are aware of the policy and receive training in its use.

Directors of Social Services should ensure that:

- NHS Trusts are assisted in drawing up appropriate child visiting policies which are consistent with the policies and approach of the local Area Child Protection Committee.

- Approved Social Workers and hospital-based social work staff are aware of the policy and receive training in its use.

- Relevant child care staff are aware of the policy and are able to provide specialist advice and assessments where necessary.

Health Authorities should ensure that:

- Mental Nursing Homes that are registered to take detained patients are aware of the contents of this guidance and follow it. Compliance with this guidance should be specified in the contract between the HA and the mental nursing home. HAs responsible for the registration of mental nursing homes should also ensure that each home has a child visiting policy.

3 Background

Paragraph 26.3 of the revised Mental Health Act 1983 Code of Practice points to the need to put in place local policies which promote good practice in the area of children visiting adult patients detained in hospital under the Mental Health Act. It also applies to children visiting detained adolescent patients. The principles of good practice discussed here are clearly applicable in <u>all</u> situations where children visit psychiatric in-patients, whether detained or not. The pursuit of good practice requires that the needs and interests of children as well as adult patients should be taken into account in formulating and implementing care plans, in professional practice and in the provision of facilities for visiting.

The objectives set out in this guidance acknowledge that the great majority of patients are admitted informally. Most visits by children to patients, whether or not detained, are central to the maintenance of normal, healthy relationships with parents or other relatives who are in hospital. In this context and in order to ensure that good practice prevails wherever children visit adult patients, this guidance applies to all patients receiving in-patient treatment and care from specialist psychiatric services, whether or not they are detained under the Mental Health Act. Staff working with patients not admitted to hospital should bear in mind the principles set out in this guidance. This will require significant practice development within mental services and between local mental health and social care agencies.

4 Application of Guidance

All hospitals that take detained patients should develop detailed child visiting policies. This will include Medium Security Units.

Health Authorities should ensure that Mental Nursing Homes that are registered to take detained patients are aware of the contents of this guidance and follow it. Compliance with this guidance should be specified in the contract between the HA and the mental nursing home.

Separate directions and guidance has been issued in relation to child visits to special hospitals[i].

5 Flexible Local Arrangements

Paragraph 26.3 was drawn in broad terms to ensure that there is a more thoughtful and positive approach to the issue of child visiting. Arrangements made for child visiting should be determined collaboratively at local level and be flexible enough to ensure that swift decisions are taken in the vast majority of cases where the matter is straightforward. In such cases, policies should aim to encourage and facilitate contacts between children and adults, which are considered to be in the child's interests. However, in a small minority of cases or situations where there may be some concern, policies on visiting clearly need to be more detailed and will involve staff in carrying out more rigorous assessments.

6 Policy Consistency

Local policies should be framed in the context of the principles that underpin the operation of the *Mental Health Act 1983* and the *Children Act 1989*. More specifically local policies should be consistent with and draw on a range of relevant national policies in this area, including other paragraphs of the Code, specifically:

- *Paragraph 2.6* which requires that the needs of the patient's family are taken into account within the process of assessing whether or not to use compulsory admission powers;
- *Paragraph 11.13* in which the ASW is required to leave an outline report at the hospital when the patient is admitted, giving reasons for admission and any practical matters about the patient's circumstances leading to the admission;
- *Paragraph 26.4,* which discusses the facilitation of child visiting, including supervision and provision of suitable, child friendly accommodation;
- *Paragraph 27.2* which defines the objectives of the *Care Programme Approach* which stresses the need for a systematic approach to the assessment of needs and the provision of care throughout the whole process;
- *A National Strategy for Carers* [ii] which discusses the specific needs of young carers and provides pointers to good practice with this group;
- Inter departmental policy guidance *Working Together under the Children Act (1989)*[iii] and new guidance on inter-agency co-operation.[iv]

7 Responsibility for Developing Child Visiting Policies

Responsibility for developing and implementing child visiting policies will lie with the Trust Board in consultation with the local SSD.

Trust Boards should nominate a senior manager to be responsible for overseeing the development of child visiting policies, monitoring their operation within the Trust, dealing with complaints and advising the Board about the implementation of the policy.

A member or members of senior ward staff should be nominated, who will have delegated responsibility for ensuring the day to day implementation of the policy and to support and supervise key workers or other staff.

8 Principles of Good Practice

Agencies may find it useful to consider policy proposals against the following indicators of good practice in this area. It is suggested that local policies aim to:

- place issues of child welfare at the heart of professional practice for all staff involved in the assessment, treatment and care of patients;
- take account of the needs and wishes of children as well as patients;
- address the whole process including pre-admission assessment, admission, care planning, discharge and after-care;
- within this process, swiftly ascertain the desirability of contact between children and patients, efficiently identify concerns and assess any risks of harm to the child;

- establish an efficient procedure for dealing with requests for child visiting in those few cases where concerns exist;
- establish a process for the facilitation of child visiting, in appropriate circumstances, which is not bureaucratic, which is supportive of children and adults, which does not cause delay in arranging contact and which maximises the therapeutic value of such contacts for both children and adults whilst ensuring the child's welfare is safeguarded;
- set standards for provision of facilities for child visiting, including provision of facilities in the hospital grounds or elsewhere;
- set standards for the training needs of all staff in relation to the consideration, facilitation and supervision of child visiting.

9 Procedures

9.1 Suggested Approach

In line with the above principles of good practice, the following indicative procedure is suggested:

(a) In those instances where a compulsory admission is being considered, the needs of and arrangements for children involved with the patient should be considered by the ASW as an integral element within the assessment. This information should be recorded by the ASW and communicated to the hospital in the event of admission. The ASW should alert their colleagues in children's services if they have any concerns about child care arrangements for dependent children of the patient. It would assist this process if documents were designed to incorporate information from this element of the assessment.

(b) Similarly, the ASW should provide the hospital with information about the views of other person(s) with parental responsibility for the children of the patient, where it is appropriate to do so and if these can be ascertained. ASWs should 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.

(c) The appropriate senior member of the ward staff who has been given delegated responsibility for taking decisions about child visits should be given the relevant information outlined in (a) and (b) above. This senior staff member should consult with other members of the multi-disciplinary hospital team, taking into account the initial assessment of the patient's needs for treatment and care and reflected in the formulation of the care plan, before taking a decision on whether a visit by a child is appropriate.

(d) When a visit by a child is anticipated, the multi-disciplinary team should swiftly and simply identify any concerns about child visiting which may be present in a limited number of cases. Arrangements will need to allow for unexpected visits by children where no previous decision has been taken. Further to this, a detailed assessment will be needed where initial concerns have been highlighted.

(e) In the vast majority of cases where no concerns are identified, arrangements should be made to support the patient and child and to facilitate contact.

(f) Staff should think creatively about how to make the visit a positive experience. They should also be sensitive to the need for privacy. The location of the visit should be considered carefully. Where the ward environment or the care needs of patients would be likely to affect the visit, arrangements should be made for visits to take place away from the main ward area. In some cases it may be better for arrangements to be made for visiting away from the hospital. In the case of detained patients this will require due consideration of the need for leave. Appropriate and

sensitive supervision should be provided where necessary. Consideration should be given to the development of innovative schemes that will develop best practice in this area.

(g) Staff should also be aware of the child protection and child welfare issues in granting leave of absence under section 17 of the Mental Health Act.

(h) Aftercare arrangements, consistent with the principles of the Care Programme Approach, should incorporate the approach set out in this guidance and acknowledge any continuing needs of the child as well as of the adult.

(i) Wards and units should include information about their child visiting policies in information booklets for patients and visitors.

9.2 Dealing with Concerns

Concerns about the desirability of child visiting may arise in a number of areas. These could relate to:

- the patient's history and family situation;
- the patient's current mental state (which may differ from an assessment made immediately prior to or after admission);
- the response by the child to the patient or his/her mental illness;
- the wishes and feelings of the child;
- the age and overall emotional needs of the child;
- consideration of child's best interests;
- the views of those with parental responsibility;
- the nature of the unit and the patient population as a whole eg. MSUs.

A useful approach to considering the best interests of children is set out in the publication *Framework for Assessing Children in Need and their Families*[v].

It needs to be borne in mind that a range of options may present themselves when concerns are identified in any of these areas. This need not automatically result in the refusal of visiting or other forms of contact. If the concerns relate to the nature of the unit or the patient population at the time the visit is proposed, arrangements should be made for visits to take place away from the ward or unit. The multi-disciplinary team must aim to obtain a balance between the management of risk and the interests of patients and children. In some situations, it may be appropriate for visiting to take place with the support and supervision of hospital staff or, indeed, other agencies. In other situations, alternative forms of contact such as by letter or telephone may be appropriate.

9.3 Decisions to refuse visits

Decisions to refuse visits, which will only be taken exceptionally, should be given in writing as well as orally and will need to be supported by clear evidence of concerns. Reasons should be given about why it was felt that the provision of support and/or the supervision of visits were thought to be insufficient to alleviate these concerns.

Local policies should clearly set out the steps to be taken in making the decision to refuse visiting, including:

- A process for consulting on concerns with the patient, the child (depending on age and understanding), those with parental responsibility, and, if different, person(s) with day to day care for the child, advocates, and where relevant, the local SSD;
- A process for communicating the decision to the patient, other family members, child and those with parental responsibility;
- A process for reviewing any decision and means of communicating this to the patient, advocate or other person or agency involved in the decision.

- A procedure to enable a patient and others with parental responsibility to make representations against any decision not to allow a visit, including access to assistance and independent advocacy. Such a system should be consistent with the hospital's overall complaints procedure and should contain an independent element.

It is advisable that these arrangements for review and complaints are formulated in consultation with local agencies, and that in particular, they are congruent with the policies and approach of the local Area Child Protection Committee.

10 Training and Practice Development

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 the appropriate attitudes, knowledge and skills especially in determining what the best interests of the child might be. The pursuit of good practice requires that specialist mental health staff consult with colleagues in SSDs. Policies need to consider how to encourage and promote the development of good practice and enable staff to deal with the understandable anxieties that may arise. As a minimum it is suggested that hospitals and social services departments should ensure that the child visiting policy and details of the local child protection policies are readily available to all staff and should put in place training programmes to:

- induct newly appointed staff in these policies;
- communicate and update child welfare and child protection policies;
- update skills;
- communicate best practice;
- disseminate and monitor complaints procedures.

Wherever possible, this training should be carried out jointly with local social services departments.

SSDs should similarly ensure that:

- ASWs are trained in child welfare and child protection policies and are enabled to update their skills either in the assessment of children at risk or in identifying risk factors and when to refer to children's services teams for assessment;
- ASWs and child protection specialists undergo joint training in issues to do with mental illness and child welfare;
- Guardians ad Litem and other relevant professionals are fully inducted into these procedures and that roles and responsibilities are clear; (*Attention is drawn to the materials produced through the Training Support Programme* [vi])
- They co-operate with NHS mental health staff to provide joint training.

11 Examples of innovative practice

In the process of drawing up this guidance attention was drawn to examples of innovative services which aim to support children in maintaining contact with parents and other adults during periods of mental illness. Details of these are attached.

This Circular has been issued by:

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Director of Health Services

Denise Platt
Chief Inspector
Social Services Inpectorate

[i] Visits by Children to Ashworth, Broadmoor and Rampton Hospitals Directions HSC 1999/160. Issued 23 July 1999.
[ii] Caring about Carers: A National Strategy for Carers. Department of Health. February 1999.
[iii] Working Together Under The Children Act 1989 – A guide to arrangements for inter-agency cooperation for the protection of children from abuse. HMSO
[iv] Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. Consultation Draft issued August 1999. Department of Health
[v] Framework for Assessing Children in Need and their Families. September 1999. Department of Health
[vi] Crossing Bridges: Training resources for working with mentally ill parents and their children – K Mayes, M Diggins and A Falkov. Pavilion Publications 1998. Department of Health.

ANNEX

EXAMPLE 1: BUILDING BRIDGES SERVICES, LEWISHAM, LUTON, TOWER HAMLETS

Building Bridges
The Building Bridges Services support families where a parent is affected by mental illness. They have been developed through partnerships between the Family Welfare Association (FWA), Social Services and NHS Mental Health Trusts locally. FWA works jointly with other professionals in planning, assessments and delivering packages of care for individual families. The services aim to meet therapeutic or emotional needs of parents and their children separately and together and to provide the family with a range of practical assistance and social opportunities. They provide counselling, group work, home visiting and support parents who are in hospital. The services also carry out assessments on parents' ability to provide appropriate care for the children and supports them in furthering their parenting role.

Aims and Objectives
- Improve children's welfare and parents' mental well-being
- Decrease disruption to families when a parent becomes mentally ill and support them through it
- Increase knowledge, skills and collaborative working across adult mental health and childcare specialisms
- Provide a variety of comprehensive services tailored to the needs of individual families and support them over short and long time periods

Key elements of the service
- An assessment is carried out, and a profile is produced of each individual ward, in order to identify potential risks to children visiting their parents. Consideration is given to how best children can have contact with their parents locally, for example where, when, timing, staff required and other resources needed to ensure the safe and smooth running of contact
- Information is gathered about any dependent children a patient has, including level of contact prior to admission and what needs to be done to maintain contact
- A local multi-agency protocol is agreed which sets out who will organise, monitor, and arrange contact between children and their parents

For further details contact Honor Rhodes, Director of Family and Community Care, FWA, 501-505 Kingsland Road, London E8 4AU. Tel: 0171 254 6251. Fax: 0171 249 5443.

EXAMPLE 2: LIAISON BETWEEN CHILD AND ADULT MENTAL HEALTH SERVICES: SOUTH LONDON AND MAUDSLEY NHS TRUST

Liaison service
Close links have been developed between the specialist child and adult mental health services in West Lambeth (previously Lambeth Healthcare Trust and now the South London and Maudsley NHS Trust). The service is small and has evolved gradually over the past 3 years, with contributions from different sources and professionals at different stages. A formal service specification has now been developed for the liaison service.

Key principles
There are a number of key principles which underpin this service:
- working within the context of the Children Act 1989 & Mental Health Act 1983
- a child welfare perspective in which children's needs (including their safety) and parental capacity to meet those needs are routinely considered

- a family perspective in which the health & social care needs of all members are considered
- a parenting perspective which brings with it recognition of the needs of patients as parents and that all adults experiencing mental ill-health have a right to expect that the needs of their children will be routinely addressed
- a preventive approach whereby explicitly addressing parental fears (e.g. expressing concerns about children or their capacity to cope leading to children being removed) can facilitate collaborative relationships and support which promotes strengths and coping skills
- drawing on the combined skills and experience of adult and child mental health practitioners, whilst ensuring clarity in roles, tasks and responsibilities

The service
Input is provided by a consultant in child psychiatry, a specialist registrar in child psychiatry and an adult CPN. On average 2 – 4 new cases are discussed each week. Staff in adult services will regularly call child mental health professionals for advice, to plan joint work and child mental health professionals attend team meetings and provide regular supervision. Joint work may involve initial assessments (home visits, at CMHCs or on wards) or ongoing therapeutic intervention. Adult workers focus on mental state assessments, monitoring of symptoms and medication and support for the parent. Child workers focus on parenting strategies, parent-child relationships and children's emotional wellbeing, including facilitating children's understanding of parental illness.

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