Discharge or Transfer to Appropriate Setting

**(Community CAMHS/ alternative MH hospital/post 18 provision)**

**Crisis or planned admission**

Attend CPA

Attend CPA

Attend CPA

Develop Care Plans; link in to areas of need identified in formulation.

Incorporate PBS into care plan such as coping skills & intervention/responses.

Debrief or chain analysis to be offered after traumatic incidents on the ward.

Discuss ABC with MDT following increase in self-harm/violent & aggressive episodes.

Work with young people in using & incorporating their skills on the ward & on leave (DBT skills, facilitating the use of skills when necessary).

Nursing team to develop a leave plan to support staff, parents & the young person

Work with young person to build routine on the ward that encourages recovery following restrictive practice & promoting independent coping/ADL skills.

Attend weekly MDT case/ward reviews & CPA meetings.

Discuss & update PBS with MDT weekly.

If detained or informal – continue to read rights; arrange referral to advocates.

Continue to liaise with families/carers/community teams.

Gather information from parents/carers for PBS before incorporating the PBS into the Care Plan.

Continue group work as in assessment phase. Provide opportunities for access to meaningful occupations.

Provide 1:1 interventions informed by OT formulation & goals.

Support to develop ADL/ independent living skills.

DBT prescription cards to be reviewed.

Attend CPA

Attend CPA

Attend CPA

Attend CPA

Formulation to be developed at 5 Day CPA & shared with all. Allocate individual assessor/therapist within 1 week of Day CPA. Family therapy assessment to be offered within 2 weeks.

Liaise with community therapist (if applicable) to gather information regarding previous therapy/reports.

Continue to collect outcome measures & carry out specialist psychological assessments/interventions, consent forms completed as required.

Therapeutic input informed by formulation, NICE guidelines & client preference with a focus on stabilisation of risks & mental state. Specialist groups available e.g. creative arts psychotherapy. Young Person joins DBT informed group program at start of next module and attend 3x weekly sessions.

Attend weekly MDT case/ward reviews and CPA meetings.

Encourage ongoing therapeutic involvement from community team if appropriate.

Joint work with community therapist/community team if appropriate.

Liaise with families/carers, Local Authority Children and families Teams and other community organisations for support with mental health and other unmet needs. Complete referrals for ss. 17 and 47 CA 1989 assessments, including s. 117 Aftercare support after discharge from hospital.

**Psychological Therapies**

Monitor mental state and risk, review physical health, review medication; review the need for MHA detention.

Attend weekly MDT case/ward reviews and CPA meetings.

Prescribe S17 leave as part of treatment.

Assess and support re: historic / current safeguarding concerns / police investigations.

Assess and support with placement and other well-being needs if young person is a Looked After Child (LAC).

Consideration of cultural and social needs, experiences of discrimination, and resources for protected characteristics.

Attend weekly MDT reviews, CPAs and Social care meetings

Write & review individual timetable & IEPs.

Provide education including trips & activities as appropriate. Liaise with home school. Regular contact with family/carers. Attend MDT case/ward reviews & CPAs.

Initial OT assessment

Jointly develop PBS Plan with the individual parents/ carers & MDT.

Begin group work &/ or 1:1 sessions to assess function by using the VdT Model of Creative Ability.

Develop OT specific formulation & contribute to MDT formulation & risk assessment.

Collaborative goal setting with young person.

DBT prescription card to be developed.

Introduce DBT Informed Groups and Obtain Commitment.

Collect initial outcome measures.

Jointly develop PBS Plan with the individual parents/ carers & MDT.

Provide recommendations for how therapeutic needs can be met in the community. Complete and share assessments, PBS and formulation reports (with consent).

Liaise with community / receiving services as appropriate.

Needs can be met in the community/transfer setting.

Contribute to service specification for placements when required.

Liaise with community team / receiving service as appropriate.

Write discharge summary report / paperwork as appropriate.

Co-produce recommendations & support for maintaining wellbeing in the community with individual parent/ carers, schools & community mental health provision as appropriate.

Support transition. Provide support with signposting/ access to meaningful occupation/ formulation of crisis or relapse prevention with self-management strategies. Where appropriate handover further OT needs to occupational therapist if OT provision is available or identify funding opportunities through S117.

Share DBT prescription cards.

Allocate key worker/key team

Start initial risk assessment. Start care plans & PBS plan.

Begin to liaise with families / carers/ community teams

Attend CPA

Attend CPA

Send out discharge paperwork.

Lead planning for school reintegration, or arranging alternative provision / employment. Support transition work to next educational destination.

To ensure the patient has a CPA booked and attendees are invited.

Upload reports onto patient record sent from other services.

**Admin**

**Education**

**Social Work**

Book 5 day CPA

Gather information on historic/ongoing social care involvement, historic/new safeguarding information/concerns, assess social circumstances and identify those with parental responsibility for collaborative partnership working.

Attend CPA

Allocate key teacher. Contact family/carers & home school for information. Carry out education assessment. Contact SEND & virtual school where appropriate.

Attend CPA

**Medical**

Assess mental state & risks.

Physical examination.

Review medication.

**Occupational Therapy**

**Nursing**

Discharge /transfer preparation

Liaise with Community team/receiving service.

**5 day CPA**

Assessment Formulation

Care Pathway

SharedGoals to work towards discharge

Can needs be safely met in community?

**Up to of 5 day CPA**

**CORE (GAU) PATHWAY through inpatient admission - MDT roles & CPA processes**

Attend CPA

**Yes**

**No**

**CPA**

Every 4-6 weeks

Review Risk and Progress

Does young person need ongoing acute inpatient care?

**Working Phase**

**No**

**Yes**