Comprehensive Health Assessment Tool (CHAT): Young People in the Secure Estate

June 2013 (Version 3)

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The **Offender Health Research Network** is funded by Offender Health at the Department of Health, and is a collaboration between several universities, based at the University of Manchester. It was established in 2004 to develop a multi-disciplinary, multi-agency network focused on offender health care innovation, evaluation and knowledge dissemination.

Surname: Forenames:
DOB: NHS Number:

CHAT ASSESSMENT OF CAPACITY AND CONSENT FORM

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	**DOB:**

Assessment of Capacity

Young people aged 16-17 are presumed in law to have capacity to give consent for themselves.

Young people under 16 can give consent, **but only** if they are able to fully understand what is proposed.

An assessment of capacity **must** be undertaken when a young person is under the age of 16 and does not want to involve parents/guardian.

Young people aged 16-17 with learning difficulties or mental health issues **must** also be assessed.

If a young person has been assessed as having capacity to consent, capacity should be **re-assessed** each time an assessment is completed.

Reception Screen	**No**	**Yes**
Is the young person currently impaired? e.g. intoxication/injury/disability	☐	☐
Does the young person have capacity to give consent for assessment?	☐	☐
Does consent need to be obtained by parent/legal guardian/person holding parental responsibility?	☐	☐

Name of professional completing capacity assessment:

Signature: Date:

Physical Health Assessment	**No**	**Yes**
Is the young person currently impaired? e.g. intoxication/injury/disability	☐	☐
Does the young person have capacity to give consent for assessment?	☐	☐

Name of professional completing capacity assessment:

Signature: Date:

Substance Misuse Assessment	**No**	**Yes**
Is the young person currently impaired? e.g. intoxication/injury/disability	☐	☐
Does the young person have capacity to give consent for assessment?	☐	☐

Name of professional completing capacity assessment:

Signature: Date:

Mental Health Assessment	No	Yes
Is the young person currently impaired? e.g. intoxication/injury/disability	☐	☐
Does the young person have capacity to give consent for assessment?	☐	☐

Name of professional completing capacity assessment:

Signature: Date:

Neurodisability Assessment	No	Yes
Is the young person currently impaired? e.g. intoxication/injury/disability	☐	☐
Does the young person have capacity to give consent for assessment?	☐	☐

Name of professional completing capacity assessment:

Signature: Date:

Consent Process

Who is providing consent? (please tick)

Young person ☐

Parent/legal guardian/person holding parental responsibility ☐

Consent for Assessment

I understand that the information I provide as part of the CHAT will remain confidential to those staff involved in my care and treatment unless someone identifies that there is, or is likely to be, a risk of significant harm to myself or others.

NB: *'Significant' means major and 'harm' includes impairment of health and development as well as ill-treatment or self-harm.*

Name:

Signature:

Date:

Surname: Forenames:
DOB: NHS Number:

Consent for Information Sharing

I understand that information may be requested from outside agencies in order to ensure that the assessment of my health is accurate and comprehensive.

I understand that in order to gain appropriate information from outside agencies, it may be necessary to share information about my current health issues.

I understand that wherever possible, permission will be sought from me to approach outside agencies for information but where delays may compromise my health, staff may approach outside agencies without my permission.

Name:

Signature:

Date:

Consent for Parent/Guardian/Person holding parental responsibility Involvement

I understand that information may be requested from my parents/carers in order to ensure that the assessment of my health is accurate and as comprehensive as possible.

I understand that my parents/carers will be informed of my current health care issues in order to support my care.

Young person's name:

Young person's signature:

Date:

If consent is refused for assessment, information sharing or parental involvement state that consent was declined and outline the reasons here:

CHAT RECEPTION SCREEN

- Every young person admitted should be seen by a member of health care staff using the CHAT Reception Screen **before the first night of arrival, ideally within 2 hours.** This should be used instead of the First Reception Health Screen (Revised F2169).

- The CHAT Reception Screen can be completed by a Registered General Nurse (RGN), Registered Nurse (specialising in children; RNC) or Registered Mental Health Nurse (RMN).

- Seek information from other assessments previously completed e.g. Looked After Children assessments, Youth Offending Service documents and insist on seeing accompanying medication and documentation. Request specialist additional information if required. Link with establishment's suicide and self-harm and restraint procedures as necessary.

- Young people with detoxification and clinical management requirements in relation to substance misuse must be seen by a Doctor prior to prescribing. Refer to '*Guidance for the pharmacological management of substance misuse among young people in secure environments'* (DH 2009). www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106433

- If you identify any **YES** (**questions 3-16 physical health; questions 5-10 in substance misuse; any in mental health/immediate safety)** complete the **relevant sections** (i.e. asthma; self-harm) of comprehensive assessment sections of the CHAT within the timeframe and complete the Immediate Care Plan to initiate urgent actions e.g. further assessment, referral to doctor, referral to substance misuse staff or heightened observations, and complete relevant Parts before the first night.

- If you identify all **NO** complete the comprehensive assessments (physical health, substance misuse and mental health) within **3 to 5 days** and the neurodisability assessment **within 10 days**. **See CHAT Manual for the CHAT Pathway flow diagram.**

Young Person Details

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	
Gender:	**DOB:**	**Age:**
Date & time of Admission:	**Date & time of Reception Screening:**	
Completed by (print your name):	**Your signature:**	
Address: **Who does the young person live with?**		

First Language:			**Interpreter Required:**				
Religion:							
Ethnic Origin	White, British White, Irish White, Other Black, African Black, Caribbean Black, Other	☐ ☐ ☐ ☐ ☐ ☐	Asian, Bangladeshi Asian, Indian Asian, Pakistani Chinese Asian, Other Mixed, White & Black	☐ ☐ ☐ ☐ ☐ ☐	Mixed, White &Asian Mixed, Other Other Ethnic Group Not Available	☐ ☐ ☐ ☐	
G.P.	Name: Address: Telephone:						
Legal Status	Is the young person a looked after child? (tick) **Yes** ☐ **No** ☐ Legal status: Please see the CHAT manual for further information about how to proceed if a young person is looked after under s31 or s.20 of the Children Act 1989. Children and young people remanded to custody will now all be looked after children for the period of the remand s.104 Legal Aid, Sentencing and Punishment of Offenders Act (LASPOA) 2012						
Next of Kin	Relationship (tick) Mother ☐ Father ☐ Other ☐ describe:						
	Name: Address: Telephone: Mobile: First Langauge: Interpreter Required: Person/s with Parental Responsibility:						
Dependants	List dependant children, siblings, parents. Include name and age/care needs. Also include any dependent pets: **Have arrangements been made for their care?** No ☐ Yes ☐ If **NO** add to Immediate Care Plan and refer to Social Services						

Surname: Forenames:
DOB: NHS Number:

Medical and Psychiatric History	Document any relevant medical or psychiatric history from accompanying records, including medication
Developmental Needs	**Does the young person have any identified developmental needs including learning difficulties, speech and language impairment or autistic spectrum disorder?** **Yes** ☐ **No** ☐ If **yes** please explain below:

Reception Screen Section One: Physical Health

One **YES** (Questions 3-16) then complete **RELEVANT SECTIONS** of the Physical Health Assessment **BEFORE** first night. Otherwise complete within 3 days.

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
1. Do you have any DIETARY requirements related to a medical health need or cultural belief? E.g. diabetes, celiac disease, lactose intolerance, vegetarian or halal. If **Yes** please provide details below and incorporate into care plan:	☐	☐
2. Do you have any ALLERGIES? E.g. to medication, nuts, pollen or latex. If **Yes** please provide details below (major reactions such as anaphylaxis and minor reaction) and incorporate into care plan:	☐	☐
3. Do you have any CURRENT BREATHING problems? E.g. asthma; wheezing; coughing; chest infection. Do not include Upper Respiratory Tract Infections or runny nose If **Yes** please provide details below:	☐	☐
4. Do you have any known HEART problems? E.g. congenital disorders or current symptoms suggestive of **HEART** problems e.g. shortness of breath or unexplained chest pain. If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

5. Do you have DIABETES MELLITUS? If **Yes**, is it treated by diet, tablets or insulin (i.e. insulin dependent versus non-insulin dependent)	☐	☐
6. Do you have a history of fits, faints or seizures (EPILEPSY)? If **Yes** please provide details below:	☐	☐
7. Are you in PAIN at this moment? If **Yes** please provide details below:	☐	☐
8. FEMALES – Are you PREGNANT or could you be pregnant? If **Yes** please provide details below: Always offer a test**.** If test positive must be seen by doctor prior to first night and incorporate into care plan.	☐	☐
9. Have you ever been diagnosed with HIV or HEPATITSIS B? If **Yes** explain below and incorporate into care plan:	☐	☐
10. Do you have a PHYSICAL DISABILITY? E.g. blindness, deafness, immobility etc. If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

11. Are you taking any prescribed MEDICATION? If **Yes** please provide details below:	☐	☐
12. Are there any unexplained SKIN rashes or spots? These may be indicative of communicable infection but do not include acne, eczema, or sweat rashes. If **Yes** please provide details below:	☐	☐
13. Have you suffered a RECENT TRAUMA (within last 2 weeks)? - E.g. wounds, sutures, bandages or bruising. May attempt to cover-up any injuries sustained during custody/enroute to custody (establish if safeguarding referral is needed) If **Yes** please provide details below:	☐	☐
14. Are vital signs abnormal? E.g. blood pressure, pulse, respirations. **Respiration** PER MINUTE **Pulse** PER MINUTE **Blood Pressure** SYSTOLIC/DIASTOLIC	☐	☐
15. Is there evidence of SHOCK? – is there evidence of pallor, fainting, thready pulse etc. If **Yes** please provide details below:	☐	☐
16. Is the young person disorientated in time, place and/or person? If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Reception Screen Section Two: Substance Misuse

If young person is showing signs of withdrawal symptoms (any **YES** to **questions 5 – 10**) then discuss immediate clinical management with a member of the clinical team (doctor/nurse) and complete **RELEVANT SECTIONS** of the Substance Misuse Assessment **BEFORE** first night.

If using alcohol or substances regularly (every day within the last month) and/or previously experienced withdrawal symptoms:-include closer monitoring for withdrawal symptoms in Immediate Care Plan and discuss with substance misuse team the next working day whether the Substance Misuse Assessment should be completed sooner. Otherwise complete within 5 days.

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
1. Have you RECENTLY (within the last month) taken drugs? If **Yes**: Which substance(s), how much, how frequently and by what route? **When did you last use any substances?**	☐	☐
2. Have you RECENTLY (within the last month) drunk alcohol? If **Yes**: **How much alcohol per day do you drink**? **How long have you been drinking like this for?** (If there is regular recent use then complete AUDIT–PC. If they score 20 or above on AUDIT-PC, arrange for immediate examination by a clinical team member)	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
3. Have you previously experienced withdrawal symptoms? If **Yes** please give details:	☐	☐
4. Is the young person currently intoxicated with alcohol/drugs? If **Yes**, consider whether screening should stop and be completed a few hours later.	☐	☐
5. Is the young person withdrawing from ALCOHOL? e.g. nausea & vomiting; sweating; tachycardia; insomnia; agitated and restless; anxious; can't sleep; hallucinations; grand mal seizures (use your observational skills) If showing active signs of withdrawal, arrange for immediate examination by a clinical team member, and monitor with Clinical Institute Withdrawal Assessment (CIWA-Ar2).	☐	☐

Surname: Forenames:
DOB: NHS Number:

6. Is the young person withdrawing from BENZODIAZIPINES (including, Valium [diazepam], Rohypnol, Temazepam, Phenazepam etc.)? e.g. nausea & vomiting; malaise; flushing & sweating; tachycardia; hyper-ventilating; panic attacks and/or phobias; over-excitable and/or aggressive; shaking/trembling; coarse tremor in hands, tongue and eyelids; insomnia; grand mal seizures (use your observational skills) If showing active signs of withdrawal, arrange for immediate examination by a clinical team member and monitor with Clinical Institute Withdrawal Assessment (CIWA-B).	☐	☐
7. Is the young person withdrawing from OPIATES (including Heroin, Morphine, Methadone etc.)? e.g. tachycardia; sweating; restlessness; pupillary dilation, runny eyes; muscle aches; runny nose and sneezing; abdominal pain; tremors and twitches; frequent yawning; anxiety or irritability; prominent gooseflesh (use your observational skills) If showing active signs of withdrawal, arrange for immediate examination by a clinical team member and monitor with an opioid withdrawal scale (for instance, the Clinical Opiate Withdrawal Scale (COWS).	☐	☐

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
8. Is the young person withdrawing from CANNABIS? e.g. anxiety; irritability; tremor; sweating and muscle pains (use your observational skills)	☐	☐
9. Is the young person withdrawing from STIMULANTS? (including Amphetamines, Mephedrone etc) e.g. lethargy; craving; increased appetite; insomnia and bizarre or unpleasant dreams (use your observational skills) Young people reporting recent heavy stimulant use and whose urine/oral fluid tests are positive for stimulants require management in a setting that has a 24-hour registered nursing presence. This includes general observation and monitoring of blood pressure for signs of hypertension and neurological observations, for the first 72 hours of custody.	☐	☐

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
10. Is the young person taking MEDICATION for substance misuse management that		

Surname: Forenames:
DOB: NHS Number:

requires continuation? A clinical drugs test must be completed and the result recorded prior to any prescribed management.	☐	☐

Review the **PHYSICAL HEALTH** section and check for **YES** answers (facets of substance misuse or withdrawal may present as physical signs and symptoms)

Surname: Forenames:
DOB: NHS Number:

Reception Screen Section Three: Mental Health Concerns

One **YES** then complete **RELEVANT SECTIONS** of the Mental Health Assessment **BEFORE** first night. Otherwise complete within 3 days.

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
1. **Do you have a previous or current history of any mental health problems e.g. ADHD or depression?**	☐	☐
Are you taking any MEDICATION for any mental health problems?	☐	☐
2. **How are you feeling at the moment?**	☐	☐
Do you feel constantly low in mood or angry? PERSISTENT LOW MOOD	☐	☐
If **Yes** - **Have you experienced any of the following recently (for at least 2 weeks): loss of appetite, sleep disturbance, feelings of hopelessness, worthlessness or guilt?**		
3. **Is the young person using any UNUSUAL SPEECH?** – Is the young person using words and phrases in an odd or bizarre way? e.g. jumbled words/disjointed or rapid speech	☐	☐

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**

Surname: Forenames:
DOB: NHS Number:

4. **Do you sometimes feel that someone is watching you or is plotting against you**?	☐	☐
Do you feel that you have special powers?	☐	☐
Does the young person have DELUSIONS? (fixed, firm beliefs without foundation in reality)	☐	☐
Is the young person behaving with excessive suspiciousness?	☐	☐
5. **Do you see or hear things that other people cannot?**	☐	☐
Is the young person HALLUCINATING? (are they responding to visual or auditory hallucinations during the assessment)	☐	☐
6. **Is s/he taking MEDICATION for mental health problems that require continuation**?	☐	☐
Document objective impression of mood and behaviour (mental state)		

Surname: Forenames:
DOB: NHS Number:

Reception Screen Section Four: Immediate Safety Risks and Concerns

One **YES** then complete **ALL RELEVANT SECTIONS** of the Mental Health Assessment **BEFORE** first night. Consider heightened observation and use local self-harm-suicide prevention procedures.

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
1. **Have you HARMED yourself in the last month?**	☐	☐
2. **Do you have FEELINGS of wanting to SELF-HARM now?**	☐	☐
3. **Have you previously ATTEMPTED SUICIDE?**	☐	☐
4. **Do you have SUICIDAL FEELINGS now?**	☐	☐
5. **Is the young person showing signs of being DEPRESSED e.g. low in mood, withdrawn; slowed down?**	☐	☐
6. **Are there any general RISKS/CONCERNS?** E.g. issues arising from ASSET; escorting officers; previous establishment; suicide/self-harm procedures; and safeguarding or child protection issues i.e. are they subject to a child protection plan?.	☐	☐

Surname: Forenames:
DOB: NHS Number:

Documents you have access to at the time of this Reception Health Screen (Tick No or Yes as appropriate)

Document	No	Yes
ASSET/AssetPlus	☐	☐
Escort Record	☐	☐
Suicide/self-harm documentation i.e. Assessment, Care in Custody and Teamwork	☐	☐
Pre-Sentence Report	☐	☐

Other documents you have access to:

Documents you have requested:

Surname: Forenames:
DOB: NHS Number:

Risk Review

Tick **No** or **Yes** as appropriate and include additional notes	**No**	**Yes**
Is the young person at risk to themselves e.g. risk of self-harm, vulnerable to bullying or poor self-care? If **yes** please explain and incorporate into the care plan	☐	☐
Have any safeguarding concerns been raised? If **yes** explain below and incorporate into the care plan **Does a safeguarding referral need to be made?**	☐ ☐	☐ ☐
Have any child sexual exploitation concerns been raised? e.g. homelessness, frequent sexually transmitted infections, risky sexual behaviour, substance misuse, frequently missing from home etc. If **yes** explain below and incorporate into the care plan	☐	☐
Have any health problems been identified that may increase vulnerability during a restraint? If **yes** explain below, incorporate into the care plan and communicate with relevant staff	☐	☐

Surname: Forenames:
DOB: NHS Number:

GO TO CARE PLANNING

CHAT Immediate Care Plan

Name:	**DOB:**	
Date:	**NHS Number:**	**Admission Number:**
ALLERGY STATUS:		

Problem	**Action**	**Who is going to do it?**	**Review Time/Date**
Completed By:		**Completed Date:**	

Surname: Forenames:
DOB: NHS Number:

CHAT PHYSICAL HEALTH ASSESSMENT

- Every young person admitted will be seen by a member of health care staff and receive a comprehensive assessment of physical health using this tool within **3 days** of arrival.
- The CHAT Physical Health Assessment can be completed by a Registered General Nurse (RGN) or Registered Nurse (specialising in children; RNC).
- Seek information from other assessments, e.g. Looked After Children assessments. Liaise with the LAC nurse or doctor regarding health assessment findings.
- Refer to other completed parts of the CHAT to inform the **care plan**.

Physical Health Assessment: Young Person's Details

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	
Gender:	**DOB:**	**Age:**
Date & time of Reception Health Screening:	**Date & time of this Assessment:**	
Completed by (print your name):	**Your designation:**	**Your signature:**

OTHER AGENCIES INVOLVED RECENTLY/CURRENTLY (Is the young person currently receiving support from any agency?) Request to share information for each agency

Involvement from agency:	**Worker Name and Contact**	**Permission to share information**
YOT Worker No ☐ Yes ☐		No ☐ Yes ☐
GP No ☐ Yes ☐		No ☐ Yes ☐
Hospital contact (outpatient & A&E) No ☐ Yes ☐		No ☐ Yes ☐
Children's Services (LAC, Children's social care) No ☐ Yes ☐		No ☐ Yes ☐
Leaving care services No ☐ Yes ☐		No ☐ Yes ☐

Substance Misuse Service No ☐ Yes ☐		No ☐ Yes ☐
Dentist No ☐ Yes ☐		No ☐ Yes ☐
Other (specify)		

Action plan: (any information to be requested specify the person to complete and timeline for completion)

Surname: Forenames:
DOB: NHS Number:

Social Circumstances

Refer To Reception Screening for Carers' And Dependants' Addresses	
Accommodation and Family:	
Prior to admission Young Person lived with:	
Parent/Guardian Relationship to young person: Does this person have parental responsibility?	Name: Address: Post Code: Telephone:
Siblings	
Children: Do you have children or are you expecting a child: please give details i.e. names, ages and who they are living with	
All Illnesses in Family Members Include parents, siblings, grandparents, uncles and aunts alive and deceased; e.g. diabetes, heart disease, hereditary conditions	

Surname: Forenames:
DOB: NHS Number:

Is the young person subject to a **CHILD PROTECTION PLAN** or **has an allocated social worker** because they are a child in need, or is known to be at **RISK** or **VULNERABLE?** - check accompanying documentation e.g. Asset, pre-court reports.

If vulnerability risks are identified put action in care plan to resolve any outstanding issues prior to discharge.

Is the young person is a **LOOKED AFTER CHILD** or has been **LOOKED AFTER** in the recent past? – if so give name and address of accommodation, responsible local authority and allocated social worker.

If vulnerability risks are identified put action in Care Plan to resolve any outstanding issues prior to discharge.

SAFE ACCOMMODATION
When the young person is discharged will they have somewhere safe to live; or will they be homeless?

Also check any safeguarding issues?

If the young person will be homeless or there are safeguarding issues put action in Care Plan to resolve this matter prior to discharge

Any other issues regarding social circumstances

Physical Health Assessment

GUIDANCE: Certain parameters have developmental norms. *Please record if the young person does not know the answers to these questions*

Weight	KILOGRAMS
Height	METRES
Respiration	PER MINUTE
Pulse	PER MINUTE
Blood Pressure	SYSTOLIC/DIASTOLIC
Temperature – axilla or oral	º CENTIGRADE
Body Mass Index	KGM / METRE²

Immunisation Status: Verify that immunisations and immunisation series have been completed.
For each state YES or NOT KNOWN (if YES include date/age).
Where vaccinations have not been received add to Care Plan

Immunisation Schedule	1st	2nd	3rd	Pre School Boosters	Post School Boosters
Diphtheria					
Tetanus					
Polio					
Pertussis					
Hib					
PCV					
Men C					

Surname: Forenames:
DOB: NHS Number:

MMR					
BCG					
HPV					
Hep A					
Hep B					
Typhoid					
Flu					
Others					

General Appearance

- observe for signs of injury; bruising; shock; impaired mobility; impaired hearing or sight; rashes and abscesses; jaundice; unusual gait; note body piercings and tattoos; observe the young person's veins - is there evidence of injecting?

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
GENERAL PHYSICAL HEALTH **– are there any general symptoms troubling you at the moment**? Please list:	☐	☐
APPETITE – are you eating more or less than usual?	☐	☐
WEIGHT - have you lost or gained weight recently?	☐	☐
FATIGUE – **have you recently felt more tired than usual?**	☐	☐
FEVER – **have you recently felt shivery or hot and cold?**	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
SWEATS – have you recently been feeling sweaty at night or any other time?	☐	☐
PAIN – have you recently had any pain anywhere?	☐	☐
MAJOR ILLNESSES – **have you ever been seriously ill?** – What? When? Outcome? Give details:	☐	☐
HOSPITAL – **have you ever been in hospital**? – Where? Why? How long? Name of consultant? Give details:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
OPERATIONS – have you ever had an operation? What? When? Where? Give details:	☐	☐
REACTION TO MEDICATION – has any medicine ever caused diarrhoea, respiratory problems or a rash? – What? When? What for? Give details:	☐	☐
CURRENT MEDICATION **- On medication now requiring continuation?** – What? Why? How frequently? **NB always check what is being said with the GP or treating doctor**	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
CARDIO-VASCULAR SYSTEM		
Do you have any problems with your heart?	☐	☐
Do you have shortness of breath, chest pain, palpitations?	☐	☐
Do you have any race-origin related problems? e.g. sickle cell disease, thalassemia	☐	☐
Vital Signs **Does the young person have any abnormalities in their vital signs?**	☐	☐
Take the radial pulse, rhythm, volume, wave; check blood pressure; signs of bulging vessels; digit clubbing; oedema; peripheral cyanosis, deep vein thrombosis.		

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
RESPIRATORY SYSTEM		
Do you have any problems with your breathing? **Vital Signs** **Does the young person have any abnormalities in their vital signs?** Observe the respiratory rate (remember vital signs are age related); look for unusual rise and fall of chest; flared nostrils; laboured breathing; cyanosis.	☐ ☐	☐ ☐
Do you have a productive COUGH? Observe any **COUGHS**, **EXPECTORATION** - sputum type: colour; rattling; wheezing.	☐	☐
Do you have ASTHMA or HAY FEVER? Listen for tightness of breath; expiratory wheeze; when does it occur; does anything exacerbate it; type of treatment e.g. inhaler.	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
TUBERCLOSIS SCREENING (COMMUNICABLE DISEASE)		
Is the young person from a high incidence country for TB or have they visited a high incidence country for more than one month in the last year?	☐	☐
Have you ever been diagnosed with TB in the past?	☐	☐
Have you had contact with someone with TB in the last year?	☐	☐
Have you ever been homeless?	☐	☐
Do you have any of the following symptoms:		
Persistent Cough	☐	☐
Coughing up blood (blood in sputum)	☐	☐
Night sweats	☐	☐
Unexplained weight loss	☐	☐
Fever	☐	☐
Lack of energy	☐	☐
Loss of appetite		

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
GASTRO-INTESTINAL SYSTEM		
Are there times when you feel like being sick?	☐	☐
Are there times when you are sick? If so, what colour is the sick? If **Yes** -could the vomiting be due to alcohol abuse?	☐	☐
Do you have any discomfort when you eat or drink?	☐	☐
Do you have pain in your stomach after eating? If **Yes**, describe what it is like; when and duration of pain and is it after a particular food?	☐	☐
Do you have any problems with diarrhoea or constipation? If **Yes**, describe the problem:	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
EYES, HEARING and ORAL HEALTH		
Do you have any problems with your EYES? – redness; soreness; photophobia; blurred or double vision.	☐	☐
Do you wear glasses/contact lenses to see? If **Yes** are you short or long sighted? **When was your eyesight last tested?**	☐	☐
Do you have any problems with your EARS or HEARING? – redness, hotness, glue-ear; infections; tinnitus; deafness (note right or left ear or both).	☐	☐
Has your sense of smell changed recently?	☐	☐
Do you have any problems with your ORAL HEALTH i.e. teeth or gums? – abnormal dentition; tooth decay; gum soreness or redness; bleeding gums; toothache. If **Yes,** please provide details below **Last visit to Dentist:**	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
GENITO-URINARY SYSTEM and MATURATION		
Do you have any problems when passing urine? e.g. frequency; pain; aches/pains in loin areas, episodes of incontinence by day or night	☐	☐
MALE		
Is the young person at the expected stage of maturation for his age?	☐	☐
A**re you aware of any problems?**	☐	☐
Have you been sexually active? If **Yes**, do you have any itching, discharge, warts or sores in your private parts? Give details:	☐	☐
Do you use any type of contraception?	☐	☐
Do you want to continue with a contraceptive when you leave custody?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
FEMALE		
Is the young person at the expected stage of maturation for her age?	☐	☐
Have your periods started?	☐	☐
Do you have any problems with your periods?	☐	☐
Do you have any bleeding between your periods?	☐	☐
Have you been sexually active? If **Yes**, do you have any itching, discharge, warts or sores in your private parts? Give details:	☐	☐
Have you ever been pregnant? Do you think you might be pregnant? Pregnancy test done? Test positive? Refused test? **Refused test/test positive need to be seen urgently**	☐	☐
Do you use any type of contraception?	☐	☐
Do you want to continue with a contraceptive when you leave custody?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
SEXUAL ORIENTATION AND SEXUAL HEALTH		
Have you decided on your sexuality? If **Yes**, indicate from the list which the young person identifies themselves as: lesbian, gay, bisexual, transgender, questioning, intersex and asexual.	☐	☐
Have you ever had unprotected sex?	☐	☐
Have you ever been tested or treated for a sexually transmitted disease? If **Yes** give details:	☐	☐
Would you like any sexual health screening e.g. Chlamydia or Gonorrhoea?	☐	☐
Would you like any sexual health information?	☐	☐
COMMUNICABLE DISEASES (consider if the young person has been sexually active/injected drugs) Explain what **HEPATITIS B** is and the risks involved; explain what testing, vaccination and management of the condition involve. Then ask:-		
Have you ever been invited to have a test for Hepatitis B?	☐	☐
If **No**, would you like to be tested? If **No,** state why?	☐	☐
Have you ever been vaccinated against Hepatitis B?	☐	☐
If **No**, would you like to be vaccinated? If **No** state why?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Explain what **HEPATITIS C** is and the risks involved; explain what testing and management of the condition involve. Then ask:-		
Have you ever been invited to have a test for Hepatitis C?	☐	☐
If **No**, would you like to be tested? If **No** state why?	☐	☐
Explain what **HEPATITIS A** is and the risks involved; explain what testing, vaccination and management of the condition involve. Then ask:-		
Have you ever been invited to have a test for Hepatitis A?	☐	☐
If **No**, would you like to be tested? If **No,** state why?	☐	☐
Have you been vaccinated against Hepatitis A?	☐	☐
If **No**, would you like to be vaccinated (explain that the Hepatitis A vaccine is given simultaneously with Hepatitis B vaccine)? If **No**, state why?	☐	☐
Explain what **HIV** is and the risks of the disease. Then ask:-		
Have you ever been invited to have counselling and a test for HIV?	☐	☐
If **No**, would you like to talk to someone about whether a test might be in your interests?	☐	☐
If the young person declines state why:-		

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **NO** or **YES** as appropriate for each question and include additional notes	**No**	**Yes**
ENDOCRINE SYSTEM		
Does the young person appear to be developing as expected? (remember that there are wide variations in developmental norms) - height; weight; skin; hair; voice	☐	☐
Are there any features of their presentation that might indicate a THYROID DYSFUNCTION? e.g. physical changes (neck; eyes; weight; hair; tachycardia) or behaviour (over-excited and excessive fidgeting or under-active, labile, slow speech and thought)	☐	☐
Do you have DIABETES? – if **Yes**, history; current medications; dietary requirements; testing regime	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
MUSCULO-SKELETAL SYSTEM		
Do you regularly EXERCISE? – sport; swimming; walking etc.	☐	☐
Do you have any pain when you walk or run?	☐	☐
Do you have any stiffness or swelling in your joints?	☐	☐
Is there anything unusual about the young person's frame, POSTURE or GAIT? - observe them sitting and walking; range of movements; alignment and symmetry; length of limbs (remember proportions are age related); deformities or swellings; involuntary movements.	☐	☐
Is there any evidence of recent TRAUMA? e.g. bruising/dressings sutures, absence of fingers/toes/limbs.	☐	☐
Have you ever BROKEN and/or FRACTURED a bone before? – it is not uncommon for adolescents to have old bone injuries that were not treated or set properly – particularly observe the knuckles for signs of this	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
NERVOUS SYSTEM		
Does the young person have any ORIENTATION problems? - ask date, time, place (remember responses will be age related)	☐	☐
Are there problems with MEMORY or recall? - ask where the young person lives; return to a question answered before; can they recall your name (remember responses will be age related)	☐	☐
Do you get regular HEADACHES? - how often; what do the headaches feel like; can the young person point to where they are?	☐	☐
Do you have an UNSTEADY GAIT - sometimes feel dizzy or unsteady on your feet? – how often; what time of day; what are they doing at the time?	☐	☐
Do you ever have FITS, FAINTS or SEIZURES? - describe what happens; duration; frequency and length; time of day; premonition; loss of sphincter control; injuries.	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Section Three: Disability and Impairment

Invitation to Declare Disability or Impairment
The youth justice system/Department of Health requires that a declaration of disability and impairment is completed (young people who have a sight or hearing impairment or have difficulties with understanding may need assistance to complete this form).

A disabled person is defined as someone who has a physical, sensory or mental impairment which has a substantial and long-term (12 months or more) effect on their ability to carry out normal day-to-day activities. For example, someone who uses a wheelchair or has difficulty in walking, someone who is deaf, someone who has significantly impaired speech or who is blind or partially sighted, someone with epilepsy or someone who has a mental illness, may be classified as having a disability. Also covered by the Act are people who have a severe disfigurement, or any medical condition that might initially have only a slight effect on a person's ability to carry out normal day-to-day activities, but which might get worse (See the Equality Act 2010 and the relevant guidance which can be found at http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/index.html)

Name: **NHS Number:**

Establishment Number (e.g. Prison) if applicable:

Inform the young person that the information on this form will be held in their personal record. The people who will see this form are staff involved with the young person during their time in the establishment. This is so that suitable arrangements may be made for their day to day activities.

1. Do you agree to give information about your needs: *Please tick appropriate box:*

   Yes ☐ No ☐ If **no**, please go to question 3 to sign the form

2. Please tick any of the following that apply to the young person and include details in the care plan and communicate with relevant staff:-

Hearing impairment	☐
Visual impairment	☐
Speech impairment	☐
Reduced mobility	☐
Difficulty with physical co-ordination	☐
Severe disfigurement	☐
Mental health problem	☐
Neurodisability e.g. autism, attention deficit hyperactivity disorder	☐
Learning difficulties	☐
Chronic long term conditions e.g. asthma, diabetes or epilepsy	☐
Progressive condition (e.g. cancer, muscular dystrophy)	☐
Other (please specify)	☐

4. Young person's signature: Date:

Surname: Forenames:
DOB: NHS Number:

Risk Review

Tick **No** or **Yes** as appropriate and include additional notes	**No**	**Yes**
Is the young person at risk to themselves e.g. risk of self-harm, vulnerable to bullying or poor self-care? If **yes** please explain and incorporate into the care plan.	☐	☐
Have any safeguarding concerns been raised? If **yes** explain below and incorporate into the care plan **Does a safeguarding referral need to be made?**	☐ ☐	☐ ☐
Have any Child Sexual Exploitation concerns been raised? e.g. homelessness, frequent sexually transmitted infections, risky sexual behaviour, substance misuse, frequently missing from home etc. If **yes** explain below and incorporate into the care plan	☐	☐
Have any health problems been identified that may increase vulnerability during a restraint? If **yes** explain below, incorporate into the care plan and communicate with relevant staff	☐	☐

Surname: Forenames:
DOB: NHS Number:

Physical Health Summary/Review

Summarise and/or review physical health concerns:

GO TO CARE PLANNING

Surname: Forenames:
DOB: NHS Number:

CHAT SUBSTANCE MISUSE ASSESSMENT

- Every young person admitted will be seen by a substance misuse worker and receive a substance misuse assessment using this tool within **5 days** of arrival.
- This will be completed by a substance misuse worker, Registered General Nurse (RGN), or Registered Mental Health Nurse (RMN).
- Seek information from other assessments, e.g. Looked After Children assessments, Youth Offending Service documents. Liaise with the LAC nurse or doctor regarding health assessment findings.
- Refer to other parts of the CHAT to inform the **care plan**.

Substance Misuse Assessment: Young Persons Details

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	
Gender:	**DOB:**	
Date & time of Reception Health Screening:	**Date & time of this Assessment:**	
Completed by (print your name):	**Your designation:**	**Your signature:**

Are there any substance misuse issues arising from other information?
Please look at other parts of the CHAT.

Summarise here:-

Does the young person think they have any substance misuse issues?

If so state what they are:-

Do the accompanying documents or information confirm what the young person is saying?
If not indicate the area of discrepancy:-
E.g. has the young person been charged with repeated acquisitive thefts, but denies substance use?

Do any of the young person's family or friends or housemates use substances?

If so state who and what they use:-

Drug/Alcohol History and Misuse

SUBSTANCE	AGE FIRST USED	CURRENT USE (within last 1/12) State amount and frequency used e.g. once per month; once per week; once per day	PAST USE (over 1/12) State amount and frequency of each substance used	CURRENT SPENDING For substances currently used, identify how much young person spends per week	ROUTE e.g. - Inject -Smoke (pipe, foil, roll) - Nasal (inhale) - Oral (bong) - Snort - Swallow	EVER OVERDOSED - Never - In past (over 1/12) -Recently (within 1/12)	EVER INCREASED USE FOR SAME EFFECT - Never - In past -Recently	TRIED BUT UNABLE TO STOP - Never - In past -Recently	EXPERIENCED WITHDRAWAL IF USED LESS - Never - In past -Recently
TOBACCO									
ALCOHOL									
CANNABIS									

Surname: Forenames:
DOB: NHS Number:

Drug/Alcohol History and Misuse (Continued)

SUBSTANCE	AGE FIRST USED	CURRENT USE (within last 1/12) State amount and frequency used e.g. once per month; once per week; once per day	PAST USE (over 1/12) State amount and frequency of each substance used	CURRENT SPENDING For substances currently used, identify how much young person spends per week	ROUTE e.g. - Inject -Smoke (pipe, foil, roll) - Nasal (inhale) - Oral (bong) - Snort - Swallow	EVER OVERDOSED - Never - In past (over 1/12) -Recently (within 1/12)	EVER INCREASED USE FOR SAME EFFECT - Never - In past -Recently	TRIED BUT UNABLE TO STOP - Never - In past -Recently	EXPERIENCED WITHDRAWAL IF USED LESS - Never - In past -Recently
OPIATES e.g. Heroin, methadone (obtained legally or illegally)									
CRACK									
COCAINE									

Surname: Forenames:
DOB: NHS Number:

Drug/Alcohol History and Misuse (Continued)

SUBSTANCE	AGE FIRST USED	CURRENT USE (within last 1/12) State amount and frequency used e.g. once per month; once per week; once per day	PAST USE (over 1/12) State amount and frequency of each substance used	CURRENT SPENDING For substances currently used, identify how much young person spends per week	ROUTE e.g. - Inject -Smoke (pipe, foil, roll) - Nasal (inhale) - Oral (bong) - Snort - Swallow	EVER OVERDOSED - Never - In past (over 1/12) -Recently (within 1/12)	EVER INCREASED USE FOR SAME EFFECT - Never - In past -Recently	TRIED BUT UNABLE TO STOP - Never - In past -Recently	EXPERIENCED WITHDRAWAL IF USED LESS - Never - In past -Recently
BENZODIAZEPINES									
AMPHETAMINE (Whizz', Speed')									
ECSTASY/MDMA									

Surname: Forenames:
DOB: NHS Number:

Drug/Alcohol History and Misuse (Continued)

SUBSTANCE	AGE FIRST USED	CURRENT USE (within last 1/12) State amount and frequency used e.g. once per month; once per week; once per day	PAST USE (over 1/12) State amount and frequency of each substance used	CURRENT SPENDING For substances currently used, identify how much young person spends per week	ROUTE e.g. - Inject -Smoke (pipe, foil, roll) - Nasal (inhale) - Oral (bong) - Snort - Swallow	EVER OVERDOSED - Never - In past (over 1/12) -Recently (within 1/12)	EVER INCREASED USE FOR SAME EFFECT - Never - In past -Recently	TRIED BUT UNABLE TO STOP - Never - In past -Recently	EXPERIENCED WITHDRAWAL IF USED LESS - Never - In past -Recently
HALLUCINOGENS e.g. LSD, Ketamine									
MEPHEDRONE ('Meow', MCAT)									
INHALANTS/VOLATILE SUBSTANCES e.g. gas solvents, aerosols, glue									

Surname: Forenames:
DOB: NHS Number:

Drug/Alcohol History and Misuse (Continued)

SUBSTANCE	AGE FIRST USED	CURRENT USE (within last 1/12) State amount and frequency used e.g. once per month; once per week; once per day	PAST USE (over 1/12) State amount and frequency of each substance used	CURRENT SPENDING For substances currently used, identify how much young person spends per week	ROUTE e.g. - Inject -Smoke (pipe, foil, roll) - Nasal (inhale) - Oral (bong) - Snort - Swallow	EVER OVERDOSED - Never - In past (over 1/12) -Recently (within 1/12)	EVER INCREASED USE FOR SAME EFFECT - Never - In past -Recently	TRIED BUT UNABLE TO STOP - Never - In past -Recently	EXPERIENCED WITHDRAWAL IF USED LESS - Never - In past -Recently
LEGAL HIGHS									
OVER-THE-COUNTER									
OTHERS:- e.g., steroids, tranquillisers									

Surname: Forenames:
DOB: NHS Number:

Withdrawal - These symptoms are derived from individual drug withdrawal scales; it is not a definitive list. Please ensure that this section is used in collaboration with the current use table (previous page) and that withdrawal symptoms are not overlooked or that other pathology is not causing the symptoms e.g. stomach upset. Young people may experiment with combinations of substances that may lead to complex presentations. If currently experiencing withdrawal symptoms refer immediately to health worker or seek medical assistance (consider use of recommended tools to monitor withdrawal symptoms - see manual for further guidance).

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Withdrawal from **ALCOHOL** e.g. nausea & vomiting; sweating; hypertension tachycardia; insomnia; agitated and restless; anxious; unable to sleep; hallucinations; grand mal seizures. If showing active signs of withdrawal, refer immediately to health worker or seek medical assistance and monitor with Clinical Institute Withdrawal Assessment (CIWA-Ar2).	☐	☐
Withdrawal from **BENZODIAZIPINES** e.g. nausea & vomiting; malaise; flushing & sweating; tachycardia; hyper-ventilating; panic attacks and/or phobias; confusion; distractibility; psychosis, depersonalisation, over-excitable and/or aggressive; photosensitivity, blurred vision; shaking/trembling/coarse tremor in hands; insomnia; grand mal seizures (If showing active signs of withdrawal, refer immediately to health worker or seek medical assistance and monitor with Clinical Institute Withdrawal Assessment (CIWA-B).	☐	☐
Withdrawal from **OPIATES** e.g. nausea & vomiting; diarrhoea, tachycardia; hypertension; sweating; restlessness; pupillary dilation, runny eyes; muscle aches; runny nose and sneezing; abdominal pain; tremors and twitches; frequent yawning; anxiety or irritability; prominent gooseflesh (If showing active signs of withdrawal, refer immediately to health worker or seek medical assistance and monitor with the Clinical Opiate Withdrawal Scale (COWS)).	☐	☐
Withdrawal from **CANNABIS** e.g. anxiety; irritability; tremor; sweating and muscle pains.	☐	☐
Withdrawal from **NICOTINE** e.g. insomnia; anxiety; bizarre dreams; fluctuating moods; derealisation; nausea and sweating.	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
SUBSTANCE USE PRACTICES		
Have you ever injected drugs?	☐	☐
Have you ever been injected with drugs by another person?	☐	☐
If **Yes**:-		
Have you ever used needles/syringes?		
Have you ever shared needles and syringes?		
Do you ever share other equipment? (filters, spoons, water, cookers, swabs etc.)		
Have you ever had a problem with your veins? NB observe the young person's veins/check findings from physical assessment of CHAT		
Have you ever had an infection resulting from injecting?		
Have you ever had an abscess where you have injected?		

DRUG/ALCOHOL SUPPLY
Where do you get tobacco and/or alcohol and/or drugs from? e.g. family, friends; internet; over the counter; off-licence/supermarket; dealer

DRUG/ALCOHOL USE

Where do you usually use the substances?: e.g. alone; with family, with friends

SPEND ON SUBSTANCE USE

How much do you spend on substance use in an average week?

Nothing – given ☐	£50 - £100 ☐	£300 - £400 ☐	£1000+ ☐
£10 - £25 ☐	£100 - £200 ☐	£400 - £500 ☐	
£25 - £50 ☐	£200 - £300 ☐	£500 - £1000 ☐	

Total monthly spend:	£
Total annual spend:	£

FUNDING OF SUBSTANCE USE

How do you pay for substances? e.g. paid income; benefits; drug dealing; sex work; theft; other (specify)

	Risk	Protective
Familial	E.g. other family members using substances, lack of direction; relationship difficulties at home or difficulties in personal life; abuse of the young person at home etc.	E.g. socially positive relationships or role models etc.
Youth Culture	E.g. local youth culture – gang membership and crime etc.	E.g. non-using friends, positive use of time, interests etc.
Educational	E.g. lack of school attendance; lack of attainment; bullying at school etc.	E.g. achievements; interests or ambitions etc.

Employment	E.g. lack of qualifications or skills; lack of work ethic; lack of purpose; poor work performance; bullying/harassment at work etc.	E.g. positive work experience, vocational interests and skills, ambitions etc.
Housing	E.g. homelessness; squatting; poor housing conditions; living with others who misuse substances; high drug use neighbourhood; frequent runaway etc.	E.g. permanent address, lives with parents/supportive family, good housing conditions etc.
Impact of Substance Misuse on Family and Others, Education and Employment and Offending Behaviour e.g. theft from home, familial disharmony, fighting with others, truanting, being sacked from work.		

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
SUBSTANCE MISUSE EDUCATION		
Have you ever received education about protecting yourself when taking drugs or alcohol e.g. sterile equipment/controlled drinking?	☐	☐
Have you ever had any health education about the health and social consequences of taking drugs/alcohol?	☐	☐
Have you ever had any education regarding the way in which tobacco, alcohol and drugs can affect your body and mind?	☐	☐
Would you like to receive some information on these issues? If the young person declines state why: Appropriate verbal as well as written information should be offered.	☐	☐
PREVIOUS TREATMENT EXPERIENCE		
Have you ever had treatment for substance misuse issues? If **Yes**:- Did you feel that it helped? If not why not? Can you remember what the treatment was?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Risk Review

Tick **No** or **Yes** as appropriate and include additional notes	**No**	**Yes**
Is the young person at risk to themselves e.g. risk of self-harm, vulnerable to bullying or poor self-care? If **yes** please explain and incorporate into the care plan.	☐	☐
Have any safeguarding concerns been raised? If **yes** explain below and incorporate into the care plan **Does a safeguarding referral need to be made?**	☐ ☐	☐ ☐
Have any child sexual exploitation concerns been raised? E.g. homelessness, frequent sexually transmitted infections, risky sexual behaviour, substance misuse, frequently missing from home etc. If **yes** explain below and incorporate into the care plan	☐	☐
Have any health problems been identified that may increase vulnerability during a restraint? If **yes** explain below, incorporate into the care plan and communicate with relevant staff	☐	☐

Surname: Forenames:
DOB: NHS Number:

Substance Misuse Summary/Review

Summarise and/or review substance misuse concerns:

GO TO CARE PLANNING

Surname: Forenames:
DOB: NHS Number:

CHAT MENTAL HEALTH ASSESSMENT

- Every young person admitted will be seen by a member of health care staff and receive a mental health assessment using this tool within **3 days** of arrival.
- This will be completed by a Registered Mental Health Nurse (RMN) or a Child and Adolescent Mental Health Service (CAMHS) practitioner.
- This assessment should also be reviewed within **3 MONTHS** of initial admission to ascertain if needs have changed and if the assessment needs to be repeated.
- Seek information from other assessments, e.g. LAC forms. Please liaise with the LAC nurse or doctor regarding health assessment findings. Link with establishment's suicide and self-harm procedures as necessary, including completion of risk assessment and management form.
- Refer to other parts of the CHAT to inform the **care plan**

Mental Health Assessment: Young Persons Details

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	
Gender:	**DOB:**	
Date & time of Reception Health Screening:	**Date & time of this Assessment:**	
Completed by (print your name):	**Your designation:**	**Your signature:**

Are there any mental health issues arising from other information? Check other CHAT parts for potential risk factors and other pertinent information. Consider any previous assessment findings and any reported speech and language and/or learning difficulties. Summarise here:-

Surname: Forenames:
DOB: NHS Number:

MENTAL HEALTH SERVICES CONTACTS Any previous contacts with GPs in relation to mental wellbeing, or with psychiatrists, psychologists, school counsellors, YOS Health Worker or CAMHS.	No ☐	Yes ☐

If **yes**, please explain below including dates and types of treatment received, non-attendance at such appointments or reasons why treatment offered was not taken up. The young person's perception of what happened with treatment and outcome and any current/previous medication for mental health problems (if there is a family history of mental illness? please give details):-

Contact details of Mental Health Practitioner or Service:

Action plan: (any information to be requested specify the person to complete and timeline for completion)

NB Care Programme Approach – care planning MUST include information gathering from all agencies

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
DEPRESSION (look for symptoms in the past 2 months) Begin by asking a general question such as "how have you been feeling over the past month or two?"		
Have you had problems with feeling sad or angry? Give details: If **yes**, how often does this happen? E.g. all day every day, sometimes every day, a few times a day?	☐	☐
Have you had problems getting to sleep or waking up too early? Give details: If **yes**, how often does this happen?	☐	☐
Are you eating much more or less than usual?	☐	☐
Have you lost weight? (record how much)	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you feel like spending less time with friends and family? (look for patterns of reduced social contact e.g. no longer playing sport, going into town)	☐	☐
Is there any time of the day when things feel worse? (e.g. morning or evening) If **yes**, when it happens can you see what might have caused it?	☐	☐
Do you still enjoy your usual hobbies and activities?	☐	☐
Do you sometimes dislike yourself or feel that everyone is better than you are?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you sometimes feel guilty about something that has happened (even if you were not involved)?	☐	☐
Do you sometimes feel everything is hopeless?	☐	☐
Do these symptoms get in the way of normal life e.g. at home, education, work settings or with friends?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
DELIBERATE SELF-HARM		
Have you ever hurt yourself? If **yes**, how have you hurt yourself?	☐	☐
How often would you hurt yourself? e.g. more than once a day, once a day, once a week	☐	☐
When did you last hurt yourself?	☐	☐
When are you likely to hurt yourself? e.g. when bored, alone, thinking about a problem	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you put yourself in dangerous situations knowing that you can get hurt?	☐	☐
Have you spoken to anyone about how to manage your self-harm?	☐	☐
Have you found ways of reducing or stopping your self-harm? What are they?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
SUICIDE RISK FACTORS		
Is this your first time in a secure establishment? i.e. Young Offender Institution, Secure Training Centre, Secure Children's Home	☐	☐
Are you currently serving a sentence, on remand or under a welfare placement? Details: If **Yes** to sentence - is your sentence (or expected sentence) longer than you expected?	☐	☐
Do you have any history of breaches of licence/bail?	☐	☐
Will you be expecting visitors?	☐	☐
Are you in contact with your family?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Was your offence against a family member?	☐	☐
Do you have any problems with dependence on drugs/alcohol? (check substance misuse part of the CHAT)	☐	☐
Have you ever tried to take your own life? If **yes**, what happened?	☐	☐
Do you sometimes think of taking your own life? If **yes**: - how often? E.g. more than once a day, once a day, once a week?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
When are you likely to think about ending your life? e.g. when you are bored, alone, thinking about a problem	☐	☐
What things worry you? (e.g. bullying, fear, threats)	☐	☐
Has a member of your family ever tried to commit or committed suicide?	☐	☐
Do you experience voices suggesting you should hurt yourself?	☐	☐
Do you find it difficult to discuss your suicidal thoughts and feelings? **Have you been able to discuss it with anyone previously?**	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
ANXIETY (look for symptoms in the past 2 months)		
Do you worry about things over and over again? If **Yes**, is there anything that has been particularly troubling you in the last month?	☐	☐
Do you sometimes worry about things before they have happened?	☐	☐
Do you worry so much that you cannot relax?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does your worry stop you from doing things, or interfere with how well you get on with your friends or family? If **Yes**, does the worry become so much that you start to panic e.g. heart racing, breathless, shaky, thoughts that something bad is going to happen to them?	☐	☐
Do you worry about going into particular situations e.g. a crowded room or situations with a large number of your peers (agoraphobia/social phobia)	☐	☐
Do these symptoms get in the way of normal life e.g. at home, education, work settings or with friends?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
POST-TRAUMATIC STRESS		
Has anything very frightening or awful ever happened to you or have you seen anything awful happen to your family or friends? (car accidents; violence; been physically or sexually hurt by others e.g. being hit or touched in a way that makes them feel uncomfortable or a sexual attack; saw someone die) If **Yes**, have you thought much about what happened in the last 2 months? If **Yes**, do you have vivid memories of what happened; flashbacks so that you can see it all again in your mind?	☐	☐
Does thinking about what happened make you feel sad?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you feel emotionally numb since it happened?	☐	☐
Do you get nightmares or bad dreams about what happened?	☐	☐
Do things happen that remind you of what happened so that you get upset?	☐	☐
Do you avoid going to places because they remind you of what happened?	☐	☐
Do these symptoms get in the way of normal life e.g. at home, education, work settings or with friends?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
PSYCHOSES		
Do you hear voices that other people cannot hear? If **Yes** please explain (clarify if using alcohol or drugs at the time)	☐	☐
Do you sometimes see things that other people cannot see? If **Yes** please explain (clarify if using alcohol or drugs at the time)	☐	☐
Do you have any unusual thoughts that other people do not seem to have? If **Yes**, please explain (clarify if using alcohol or drugs at the time)	☐	☐
Do you ever feel controlled by a force or power outside yourself, controlling your thoughts or actions? If **Yes** please explain (clarify if using alcohol or drugs at the time)	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you ever worry that someone is putting or removing thoughts from your head? If **Yes** please explain (clarify if using alcohol or drugs at the time)	☐	☐
Do you ever feel that some people are too interested in you or trying to hurt you? e.g. someone is watching you or is plotting against you If **Yes** please explain? (clarify if using alcohol or drugs at the time)	☐	☐
Do you ever feel that you have special powers? If **Yes** please explain? (clarify if using alcohol or drugs at the time)	☐	☐
Corroborative View - Are there any corroborating observations recorded about the young person that would confirm the **Yes** answers above either currently or previously? If so, state source(s):-		

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
ATTENTION DEFICIT HYPERACTIVITY DISORDER (symptoms should be present since childhood and pervasive across different settings)		
Do you find it difficult to sustain attention or concentrate?	☐	☐
Do you often feel restless, especially in situations where it is inappropriate?	☐	☐
Do you interrupt people a lot so that they get upset with you?	☐	☐
Do you find it hard to sit still or do people often tell you to stop fidgeting?	☐	☐
Do you find it difficult to wait for your turn?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Do you find it difficult to organise tasks and activities?	☐	☐
At what age did these problems first start?		
Has a (medical practitioner) Doctor or someone like that ever told you that you have a hyperactivity disorder or ADHD? If **Yes**, who:-	☐	☐
On observation is the young person fidgety, distractible or impulsive?	☐	☐
Do these symptoms get in the way of normal life e.g at home, education, and work settings or with friends?	☐	☐

ACTION FOR CARE PLAN

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**

Surname: Forenames:
DOB: NHS Number:

EATING DISORDERS (look for symptoms in the past 2 months)		
Do you diet or binge eat frequently? If **Yes** please explain:	☐	☐
Do you sometimes make yourself sick because you are too full? If **Yes** please explain:	☐	☐
Have you tried to lose weight in any other way e.g. exercising/using laxatives? If **Yes** please explain:	☐	☐
Do you think that you are fat or overweight? Do other people think the same?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does food dominate your thinking and life?	☐	☐
Have you lost a lot of weight in the last 3 months? If **Yes** then how much?	☐	☐
Do these symptoms get in the way of everyday life e.g. at home, education, and work settings or with friends?	☐	☐
Any concerns from the physical health assessment (part 2) of the CHAT or centile chart for weight/BMI?	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Risk Review

Tick **No** or **Yes** as appropriate and include additional notes	**No**	**Yes**
Is the young person at risk to themselves e.g. risk of self-harm, vulnerable to bullying or poor self-care? If **yes** please explain and incorporate into the care plan.	☐	☐
Have any safeguarding concerns been raised? If **yes** explain below and incorporate into the care plan **Does a safeguarding referral need to be made?**	☐ ☐	☐ ☐
Have any child sexual exploitation concerns been raised? e.g. homelessness, frequent sexually transmitted infections, risky sexual behaviour, substance misuse, frequently missing from home etc. If **yes** explain below and incorporate into the care plan	☐	☐
Have any health problems been identified that may increase vulnerability during a restraint? If **yes** explain below, incorporate into the care plan and communicate with relevant staff	☐	☐

Surname: Forenames:
DOB: NHS Number:

Mental Health Summary/Review

Summarise and/or review mental health concerns:

GO TO CARE PLANNING

Surname: Forenames:
DOB: NHS Number:

CHAT NEURODISABILITY ASSESSMENT

- Every young person admitted will be seen by a member of health care staff and receive a neurodisability assessment using this tool within **10 DAYS** of arrival.
- This will be completed by a Registered Mental Health Nurse (RMN), Child and Adolescent Mental Health (CAMHS) Practitioner or a Registered Learning Disability Nurse.
- Prior to interview with the young person, review their notes and discuss their presentation/functioning with a staff member who knows them well to obtain any relevant information. Look for any evidence of special schooling, school difficulties/exclusions, early developmental problems, injuries, reports that may indicate learning disability, speech and language or social communication difficulties (autistic spectrum disorders).
- Refer to other parts of the CHAT to inform the **care plan**.

Neurodisability Assessment: Young Persons Details

Surname:	**Forenames:**	
NHS Number:	**Admission Number:**	
Gender:	**DOB:**	
Date & time of Reception Health Screening:	**Date & time of this Assessment:**	
Completed by (print your name):	**Your designation:**	**Your signature:**

Are there any neurodisability issues arising from other information? Check other CHAT parts for potential risk factors and other pertinent information. Consider any previous assessment findings and any reported speech and language and/or learning difficulties. Summarise here:-

Traumatic Brain Injury

This section focuses specifically on Traumatic Brain Injury. Traumatic Brain Injury – is when the head receives a severe blow or jolt, for example in an accident, fall or assault, the brain can be damaged. There are other forms of Acquired Brain Injury which may have been caused by a stroke, haemorrhage, infection, hypoxic/anoxic brain injury and medical accidents. These are not included here, but check whether the young person has experienced any of these as they may influence their presentation.

Any loss of consciousness (LoC) over 30 minutes **OR** repeated loss of consciousness on more than three occasions (any length of time) where the young person has experienced symptoms following the injury:-

- **Review physical health/medical records and CHAT assessment (contact GP if necessary).**
- **Discuss with health worker need for further assessment of acquired brain injury (persistent symptoms for 3 months following a head injury requires further assessment and investigation while recent head injury also requires medical advice)**
- **For all young people who have experienced traumatic head injuries and have ongoing symptoms (those with and without LoC) take account of their symptoms within the care plan e.g. daily living skills and occupational functioning**

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Have you ever had an injury to the head that caused you to be knocked out and/or dazed and confused? E.g. from a fall, blow to the head (including boxing or fighting) or road traffic accident. If **Yes**, please explain: If **No**: move onto Learning Disability and Educational Needs	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
How many times have you been knocked out and/or dazed and confused? For each occasion ask how it happened. **When was the last occasion?**		
Did you seek any medical attention after being knocked out and/or dazed and confused? If **Yes**, what treatment did you receive? Did you have to stay in hospital?	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick boxes that describe the worst time s/he has been knocked out and/or dazed and confused.				
	Dazed or confused	**Unconscious for < 30 min**	**Unconscious for > 30 but < 60 min**	**Unconscious for > 60 min**
Road accident (as a pedestrian, cyclist or by car)				
Fall when sober				
Fall when under the influence of drink/drugs				
Sports injury e.g. boxing				
Fight				
Other				

Surname: Forenames:
DOB: NHS Number:

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms below. As many of these symptoms can occur normally, we would like to compare yourself now with before the accident. For each one please check the box that best describes your experiences.

Compared with before the accident, do you **NOW** suffer from:-

	Not experienced at all	**No more of a problem**	**A mild problem**	**A moderate problem**	**A severe problem**
Headaches					
Feelings of dizziness					
Nausea and/or vomiting					
Forgetfulness, poor memory					
Poor concentration					
Confusion					
Fogginess					
Difficulties recalling everyday events					

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Speech, Language and Communication Impairment

Use your observational skills and include information from other sources e.g. previous reports and information from parents, carers and other professionals working with the young person.

If the young person struggles with the narrative task <u>OR</u> has a YES response for any aspect of SECTION 2 this may indicate a possible language and communication difficulty.

Action:

- **If a diagnosis of speech, language and communication needs is already made, include the diagnosis and strategies to help support the young person in the care plan.**
- **If not diagnosed but the young person presents with suspected speech, language and communication needs discuss the care plan with a member of the Mental Health Team (psychiatrist, psychologist or senior nurse). It is important to discuss the assessment findings in the context of the young person's age and wider needs (e.g. learning/mental health) as well as current functioning.**
- **Consult with a speech and language therapist to identify those requiring further assessment or intervention.**

Example answers for Narrative Task:

a) Setting up a table to start a game of pool
Get the balls and put them on the pool table. Put the coloured balls in the triangle and then remove the triangle. Put the white ball on the spot/ top of the table and hit the white ball with the cue into the coloured balls.

b) Making a cheese sandwich
Cut 2 slices of bread from a loaf or take 2 slices of bread from the packet and put them on a plate. Open the fridge and get out the cheese and the butter/margarine. Use a knife to spread the butter on the bread. Then cut a few slices of cheese and put them on one slice of bread on top of the margarine. Put the other slice with the butter facing down on top of it. Then cut it in half.

c) Putting on a DVD
Turn on the DVD player (and the TV if watching through that). Take the DVD from its box. Use the remote or press the button to open the DVD drawer. Put the DVD onto the drawer and press the button again so it goes back in. Press 'play' on the remote and then select/choose what you'd like to watch.

d) Choosing and playing an X box or Play station game
Turn on the TV and Xbox. Choose a game and take it out for its box. Use the controller or press the button on the X box to open the (X Box) disc tray. Put the game into the tray/drawer and press the button again so it goes back in. Select the right TV channel with the TV remote. Use the controller to select the game, what level you are at and other options. Then start the game.

e) Buying something to eat from a fast food place, café or shop (give examples of what is local to the young person e.g. McDonalds, Greggs)
Make sure you have some money. Go into the shop/café. Decide what to buy by looking at what is on the menu or on display. Check that you have enough money and go to the counter. Ask for what you would like, give enough money and take any change that's given back. Wait for your food and then eat it

Surname: Forenames:
DOB: NHS Number:

NARRATIVE TASK

Ask the young person to explain how to do one of the following activities. Read through the following list and let them choose one;

a) **Setting up a table to start a game of pool;**

b) **Making a cheese sandwich;**

c) **Putting on a DVD to watch;**

d) **Choosing and playing an X-box/Play station game; OR**

e) **Buying something to eat from a café, shop or fast food place**

If none of the examples seem appropriate let the young person talk through the stages of an activity of their own choice.

Ask the young person: - **"Tell me how to do one of these activities. I need you to give me as much detail as you can. I will write down what you say."**

If they rush the task give prompts to encourage them to give more detail.

Young Person Answer:		
Tick **No** or **Yes** as appropriate for each	**No**	**Yes**
From the answer given above – did the young person?	☐	☐
Use appropriate words/vocabulary	☐	☐
Explains the stages of the activity in the correct order	☐	☐
Includes all the obvious stages	☐	☐
Uses **both** simple short sentences (e.g. Put the balls on the pool table) and more complex ones which include combining words such as "after/ before/when/until" (e.g. After you put the coloured balls in the triangle)	☐	☐

NO on 2 or more - may indicate a possible language and communication difficulty.

If young person fails in only one area then consider repeating the task using another example (see manual for more information)

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

SECTION 2. INFORMATION FROM INFORMANTS/RECORDS/OBSERVATIONS

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does the young person have a history of speech and language delay or difficulties? If **Yes** please provide details below:	☐	☐
Has the young person had previous speech and language therapy? If **Yes** please provide details below:	☐	☐
Does the young person have a speech problem or find it hard to say words clearly? e.g. stammer or its difficult to understand them If **Yes** please provide details below:	☐	☐
Does the young person have difficulty understanding what I say? If **Yes** please provide details below:	☐	☐
Does the young person find it hard to understand long or complicated words/instructions? If **Yes** please provide details below:	☐	☐
Are their responses minimal or very limited to one answer with minimal spontaneous elaboration or description? If **Yes** please provide details below:	☐	☐
Does the young person find it hard to explain things or gets stuck on words when speaking? If **Yes** please provide details below:	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Learning Disability and Educational Needs

Initially obtain information from other staff working with the young person currently (both education staff and key worker/personal officer) and information from records including ASSET prior to the assessment. When interviewing the young person have access to a magazine and non-digital clock (wrist watch or wall clock in room) and use your observational skills

- **If diagnosis of learning disability already made include in the care plan.**
- **If not diagnosed but presents with possible learning disability or educational needs discuss with education team or Mental Health team (psychologist/psychiatrist or senior nurse) if further specialist assessment required (all young people with functional impairment should be considered)**

INFORMATION FROM INFORMANTS AND RECORDS Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does the young person have a statement of special educational needs? If **Yes** please provide details below:	☐	☐
Has the young person attended a specialist school (non-mainstream)? If **Yes** please provide details below:	☐	☐
Has the young person ever been in contact with specialist learning disability services? If **Yes** please provide details below:	☐	☐
Are there concerns from education staff that the young person has any learning needs? If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does the young person need significant coaching in order to complete tasks e.g. making beans on toast or washing laundry? If **Yes** please provide details below:	☐	☐
Can the young person only maintain their daily routine (e.g. washing/getting to school or work) with imposed structure or prompting? If **Yes** please provide details below:	☐	☐
Does the young person have problems attending to personal hygiene independently? If **Yes** please provide details below:	☐	☐
Is the young person excessively vulnerable within their peer group? If **Yes** please provide details below:	☐	☐
Are there any accompanying records that indicate that the young person has an IQ<70 (learning disability) or learning needs (generalised or specific)?	☐	☐

Surname: Forenames:
DOB: NHS Number:

INFORMATION FROM THE YOUNG PERSON Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Have you struggled with schoolwork? If **Yes** please provide details below: (clarify whether in primary, secondary school or both)	☐	☐
Did you have any additional support in lessons? If **Yes** please provide details below:	☐	☐
Has anyone told you that you have a learning disability or learning needs? If **Yes** please provide details below:	☐	☐
Do you struggle with reading or writing? (show them a story in a magazine and discuss it with them) If **Yes** please provide details below:	☐	☐
Do you struggle telling the time? (check using non digital clock) If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

ADDITIONAL INFORMATION Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Does the young person have difficulties following the conversation? If **Yes** please provide details below: **Did you have to rephrase the questions to clarify?** (always check whether the young person has understood the information - use your observational skills) If **Yes** please provide details below:	☐ ☐	☐ ☐
Does the young person have difficulties expressing themselves? (use your observational skills) If **Yes** please provide details below:	☐	☐
Information Confirm information with parent/carer or other professional (provide details below)		

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Autistic Spectrum Disorder

Start by having a conversation with the young person about their family and friends and what they enjoy doing. Give them prompts to describe their experiences if necessary. Then change the conversation to a different topic, for example telling them about your interests and experiences and assess if the young person can follow your topic and shows interest.

Complete the following questions using your observations AND with information from the young person's key-worker, personal officer or YOT worker. Also include information from previous documents/assessments prior to the interview. Make additional notes below providing examples.

If YES for any question from two different sections (sections 2, 3 or 4) OR any YES to section 1:

- **If diagnosis of ASD already made include in care plan.**
- **Discuss care plan with Mental Health Team (psychiatrist, psychologist or senior nurse). This may include further assessment using ASD specific screening tools (for example Social Responsiveness Scale or Social Communication Questionnaire) and obtaining further information from a parent/carer.**
- **If further information confirms social communication difficulties consider referral to local CAMHS team on release for specialist ASD assessment (provide all relevant assessments to date).**

If YES for any question on one section (section 2, 3 or 4) or other subtle social difficulties noted: - repeat assessment in 4 weeks.

Section 1: From the notes

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Has the young person ever been assessed or diagnosed with an autistic spectrum disorder (ASD), pervasive disorder not otherwise specified (PDD-NOS) or pragmatic language impairment/semantic pragmatic disorder? If **Yes** please provide details below:	☐	☐
In current/previous notes has a professional or family member expressed concerns that the young person has social communication difficulties? If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Section 2: During conversation do you notice the following about the young person

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Speaks in a monotonous or unusual voice e.g. like a robot If **Yes** please provide details below:	☐	☐
Shows little interest in the interviewer's description of their experiences/interests If **Yes** please provide details below:	☐	☐
Takes things literally and fails to understand implied meanings, inference, jokes or sarcasm. Note if the person misinterprets a question and you need to re-phrase the question using concrete examples. If **Yes** please provide details below:	☐	☐
Talks about the same thing over and over e.g. repetitive talk about a particular hobby or difficulty stopping their topic to follow the interviewer's introduction of a new topic. If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Section 3: In social interactions do you notice the following about the young person

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Has a limited understanding of different types of relationships e.g. finds it difficult to describe the difference between a peer and a best friend. If **Yes** please provide details below:	☐	☐
Does not like looking at people when talking or listening. If **Yes** please provide details below:	☐	☐
Has a limited range of facial expressions or expressions do not match what they are saying. If **Yes** please provide details below:	☐	☐
Is socially awkward or inappropriate even when trying to be polite. If **Yes** please provide details below:	☐	☐

Surname: Forenames:
DOB: NHS Number:

Section 4: Does the young person display the following

Tick **No** or **Yes** as appropriate for each question and include additional notes	**No**	**Yes**
Has more difficulty than other young people with change in their routine. If **Yes** please provide details below:	☐	☐
Unaware or uninterested in what other people their age are interested in e.g. hobbies/music/clothes. If **Yes** please provide details below:	☐	☐
Has an unusual/excessive reaction to sensory stimuli (touch/sound/smell/taste) e.g. responds negatively to loud or unexpected noises. If **Yes** please provide details below:	☐	☐
Is inflexible, has a hard time changing their mind. If **Yes** please provide details below:	☐	☐
Has interests that are either obsessive (time consuming), unusual or very narrow in range. If **Yes** please provide details below:	☐	☐

ACTION FOR CARE PLAN

Surname: Forenames:
DOB: NHS Number:

Risk Review

Tick **No** or **Yes** as appropriate and include additional notes	**No**	**Yes**
Is the young person at risk to themselves e.g. risk of self-harm, vulnerable to bullying or poor self-care? If **yes** please explain and incorporate into the care plan.	☐	☐
Have any safeguarding concerns been raised? If **yes** explain below and incorporate into the care plan	☐	☐
Does a safeguarding referral need to be made?	☐	☐
Have any child sexual exploitation concerns been raised? E.g. homelessness, frequent sexually transmitted infections, risky sexual behaviour, substance misuse, frequently missing from home etc. If **yes** explain below and incorporate into the care plan	☐	☐
Have any health problems been identified that may increase vulnerability during a restraint? If **yes** explain below, incorporate into the care plan and communicate with relevant staff	☐	☐

Surname: Forenames:
DOB: NHS Number:

Neurodisability Summary/Review

Summarise and/or review neurodisability concerns:

GO TO CARE PLANNING

Surname: Forenames:
DOB: NHS Number:

CHAT CARE PLAN

Name:	**DOB:**	
Date:	**NHS Number:**	**Admission Number:**
PHYSICAL HEALTH (overall summary):		
Physical Health Completed By:		**Date:**

SUBSTANCE MISUSE(overall summary):	
Substance Misuse Completed By:	**Date:**

Surname: Forenames:
DOB: NHS Number:

MENTAL HEALTH(overall summary):	
Mental Health Completed By:	**Date:**

NEURODIABILITY (overall summary):	
Neurodisability Completed By:	**Date:**

Surname: Forenames:
DOB: NHS Number:

Problem/Issue	Intervention/Action Required	Goal	Who is going to do it?	By When?
Completed By:		**Completed Date:**		
Young Person Signature:				

Surname: Forenames:
DOB: NHS Number:

CHAT DISCHARGE/TRANSFER CARE PLAN

Name:	**DOB:**	**NHS Number:**
Date of Admission:	**Date of Discharge:**	**LAC Status & Local Authority:**
Discharge/Transfer Address:	**Current/Recent Medication:**	
Permanent GP **Name:** **Address:** **Telephone:**	**Allergies:**	
Known Vaccinations:	**Outstanding Vaccinations:**	

Surname: Forenames:
DOB: NHS Number:

Initial Weight: **Date:** **Initial Height:**	**Discharge Weight:** **Date:** **Discharge Height:**
Chronic Conditions:	**Risk Issues to Others:** **Safeguarding Issues:**
Recent and/or Outstanding Appointments:	
Recent Contacts: **Date:** **Dental:** **Optician:** **Physiotherapist:** **Podiatrist:**	**Any other relevant contact:** **Date:**

Health Recommendations/Outstanding Actions for Young Person			
Problem/Issue	**Intervention/Action Required**	**Goal**	**Responsible Person**
Summary of any current or previous Physical Health concerns:			
Summary of any current or previous Substance Misuse concerns:			

Surname: Forenames:
DOB: NHS Number:

Summary of any current or previous Mental Health concerns:			
Summary of any current or previous Neurodisability concerns:			

Summary of any current or previous Educational/Employment needs:			
Completed by:		**Date Completed:**	
Address:		**Signature:**	

Copy sent to:

Name:	**Address:**	**Date:**

Surname: Forenames:
DOB: NHS Number: