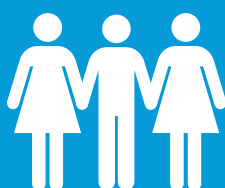


CAMHS in Context

Helping you to achieve better outcomes
for children, young people and families



National CAMHS Support Service

National Workforce Programme

CONTENTS

		Page
	Introduction	1
Chapter 1	Children, young people and families	
Section 1a	The Child's World	5
Section 1b	Teenage Years	13
Section 1c	The family context	19
Section 1d	Sensitive and effective working	26
Section 1e	Case Study 1	31
	References	34
Chapter 2	Mental health and emotional well being	
Section 2a	Positive Mental Health and Promotion	35
Section 2b	Theories and approaches – social and psychosocial ways of thinking about mental health	42
Section 2c	Using evidence	52
Section 2d	Mental health problems and disorders, assessment and intervention	57
Section 2e	Case Study 2	74
	References	78
Chapter 3	Working in specialist CAMHS	
Section 3a	The structure of specialist CAMHS	79
Section 3b	The Specialist CAMHS Team	85
Section 3c	Caseload	95
Section 3d	Clinical Governance	104
Section 3e	Case Study 3	110
	References	114
Chapter 4	Collaborating with other people/agencies	
Section 4a	The children's services landscape	115
Section 4b	Local partnerships and commissioning	121
Section 4c	Service User Participation	125
Section 4d	Inter-agency working	132
Section 4e	Case Study 4	141
	References	144
Chapter 5	Continuing Professional Development	145
Self Test 1a	The child's world	152
Self Test 1b	Teenage Years	153
Self Test 1c	The family context	154
Self Test 1d	Sensitive and effective working	155
Self Test 2a	Positive mental health and promotion	156
Self Test 2b	Theories and approaches	157
Self Test 2d	Matching exercise	158
Self Test 4c	Service User Participation	159
Self Test 4d	Inter-agency working	160
Solutions 1a	The child's world	161
Solutions 1b	Teenage years	162
Solutions 1c	The family context	163
Solutions 1d	Sensitive and effective working	164
Solutions 2a	Positive mental health and promotion	165
Solutions 2b	Theories and approaches	166
Solutions 4c	Service User Participation	167
Solutions 4d	Inter-agency working	168

Introduction

Welcome to **CAMHS in Context**, the Induction to Specialist CAMHS.






We hope that **CAMHS in Context** will clarify the expectations of your new role, help you acclimatise to the world of CAMHS and children's services and inspire you to achieve excellence in working for better outcomes for children, young people and families.

What induction means

The term 'induction' is generally used in a workplace context to describe the whole process whereby employees adjust or acclimatise to their jobs and working environment. Every organisation, large or small, should have a well-considered induction programme. The induction programme has to provide all the information you need and are able to assimilate, without being overwhelming or diverting you from the essential process of integration into a team.

Purpose of this induction

The purpose of induction is to ensure the effective integration of staff into or across the organisation for the benefit of both parties. Much of your induction will take place at your workplace, covering areas such as:

-  Physical orientation - describing where the facilities are.
-  Organisational orientation - showing how you fit into the team and how your role fits with the organisation's strategy and goals.
-  Health and safety information - this is a legal requirement.
-  Explanation of terms and conditions.
-  A clear outline of the job/role requirements.




This induction pack is to help you integrate more broadly into the world of specialist CAMHS with its links to child health and wider children's services. It is based on the Core Functions for Specialist CAMHS, developed by Skills for Health and reflects the range of knowledge, skills and values necessary to be an effective practitioner in this complex field.

Throughout the materials you will be invited to jot down ideas, reflect or test yourself and for this purpose we advise you to buy a notebook so you have a record of your learning that can also serve as a reflective journal.




You are reading the pdf workbook, which may be printed; there is also an interactive CD.

Approaches to learning

In the induction package we have used a variety of learning activities designed to:

-  inform you about national policy and its influence on CAMHS and children's services;
-  introduce you to the main functions of your role as a CAMHS worker; and
-  encourage you to think and test out your ideas in becoming an effective practitioner.

The learning activities are designed for you to work through at your own pace, saving your responses and answers as you go. You will have your own preferred style and pace of learning and, in offering a variety of formats and approaches, we have tried to cater for all preferences. The main approaches are:

-  information giving;
-  self assessment;
-  experiential learning.

These are explained in more detail below.

Information giving

Diagrams and pictures

Where information is readily conveyed in a chart, table, diagram or picture, these are provided. Sometimes the figure will build up in a PowerPoint slide which you control with the mouse.

Text boxes

Some information will be in text boxes, with references to source material in the bibliography. Much of the information we have used is drawn from an induction package developed in Scotland, called *New to CAMHS*; all text from this source is clearly marked as below:

Information from New to CAMHS always appears in columns on a pale orange background like this. Each extract is referenced to the page numbers in the

original document, which you have in the resources section of this package.

Self assessment

Just for your own purposes, to check you have retained and understood, there will be brief self assessment activities, such as filling in the missing word or sentence completion, true/false quiz, matching concepts and completing diagrams.

Experiential learning

Learning *from* experience

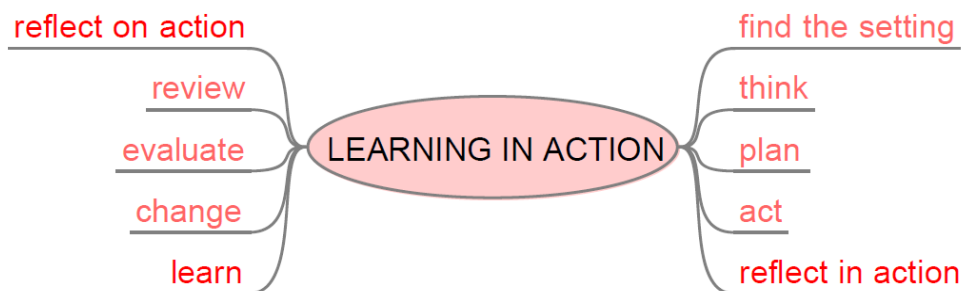
This is about introspecting, using your past experiences and memories to consider how you can adapt and apply the learning to the issue in hand.

In the introspection activities you will be asked to look back into aspects of your own life and think about what you can learn from those experiences. Examples of other people's introspections will be offered for you to consider. These examples should not be seen as the right answer, but are there to offer different perspectives.



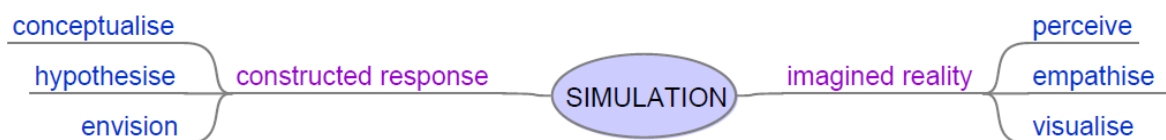
Learning by *simulated* experience

Learning from simulation includes the use of case studies and scenarios. In this type of experiential learning you will be asked to imagine or re-construct a situation, seeing it from a number of different perspectives. Again you will be offered sample responses with which to compare your own. At the end of each section you will be directed to the case study, which builds up over time and encourages you to think about the application to practice of the materials in the induction.



Learning by *having* experiences

Sometimes you will be asked to go and try out a simple activity in your workplace or other real life setting, then discuss it with a trusted colleague and/or reflect on the experience. This is a way you can test out some of the ideas in the induction and see how they work in reality.



Other perspectives: your shadow learner

Your reflections on your experiences are valuable in their own right, but it can be helpful to share experiences with others. If you have a learning mentor and/or a trusted colleague, you will be able to share ideas with them. In addition, each time you participate in an experiential activity some alternative thoughts will be offered from the shadow learner. The shadow learner feedback is based on the real experiences of the writing team.

Keeping a record

When you are working through these materials you will want to make your own notes and jot down answers to the self assessments and as recommended earlier a notebook is the best option.

We hope that everyone using this pack for their induction will have a learning mentor as well as other trusted colleagues with whom to share ideas and think about how they relate to practice. Your notebook will be a useful aide-memoire for these discussions.

Learning mentor

You need to approach a senior member of the team to support your induction as your learning mentor. There is support for learning mentors on Disc 2 of the pack.

The induction package is also a resource bank that you can dip into at any time, so extracts from relevant sections are available for you to save on your own computer and/or print off. The extracts are available as charts and diagram, tables and checklists.

These materials were produced for Skills for Health and the National CAMHS Support Service (NCSS) Workforce Programme in 2009-10, by the writing team at Cernis. Cernis is an independent organisation that specialises in developing children's services, particularly those dealing with mental health and emotional well being.

The Cernis writing team comprised:

Yvonne Anderson	Managing Director
Anna Devereux	Service Analyst
Ian McGonagle	Associate (principal lecturer Lincoln University)

A reference group representing employers, practitioners and commissioners from around the country was consulted at the initial design stage and provided feedback on draft sections.

The endeavour was led and steered by:

Marc Lyall	Divisional Manager Health Policy Team, Skills for Health
Barry Nixon	National Workforce Lead CAMHS

The child's world

"If you carry your childhood with you, you never become older."

Tom Stoppard (1937)

British playwright

Increasingly, research has borne out what families have always known – infants come into the world 'hard-wired' to relate – hungry not only for food, but also for emotional engagement. Being loved, held and cared for are central to an infant's sense of well-being and to their development. In short, an infant's physical, intellectual and emotional experiences are inextricably linked.

Young children depend on those caring for them not only to provide for their basic needs, but also to modulate and interpret the world and their experiences to help them make sense of what is happening and how they are feeling. It is through repeated interactions between the infant and his primary care-giver that a sense of self and the capacity to think is established. When mediated by someone who can receive and respond to the infant's need for love and understanding, he will gradually begin to take in a feeling of being understood and to

develop his own capacity to understand himself and others.

Over time, a cognitive and affective 'map' of self and other is built up through an infant's interactions and relationships. This model shapes the way a child anticipates, predicts and relates to the world, based on their experiences. That is, securely attached children generally expect others, both adults and children, to be responsive, and relationships to be reciprocal, they generally have a view of themselves as worthy of positive regard and affection. But children who have been on the receiving end of adverse experiences — such as witnessing domestic violence, or physical, sexual or emotional abuse or deprivation — may be wary of others, and be unable to trust. Because assumptions about self and others are relatively stable and not easily changed, this can colour and distort the way a young child sees things and their relation to the external world.

New to CAMHS pp 68-69 edited

How much of who you are now was formed when you were young? Who or what do you see when you look at photographs of yourself as a child? How did others describe you as a child? Record your thoughts and ideas, then compare your responses with the shadow learner below.

I look at photos of myself aged about 5 or 6, gazing into the camera, looking solemn and thoughtful. Adults described me as "a bookworm". I look self contained and still have that ability today to be alone with myself and content to be solitary, thinking or reading. Often in photos I am holding one of my younger siblings, or have my arm round them. My role as the older protective one looks as if it was already established. Now, as a parent and a manager I still have the urge, or need, to protect, nurture and guide.

Photos or recalled images can reveal powerful childhood memories and remind us of what it is like to be a child in an adult world.

The concept of an Inner World also encompasses the idea of unconscious fantasies and primitive anxieties, which can be experienced by children concretely. Often parents and workers attempt to reassure children who are distressed — to no avail — because not enough attention is given to understanding their perception of events, which may be very different from reality. Bad dreams and irrational fears beset even the most loved and nurtured child. Young children can quickly be gripped by fears of abandonment, starvation or retaliation, fears of witches, ghosts, or demons. Young children also worry about their feelings of greed, possessiveness and potential destructiveness. Might their hatred in fantasy, and their anger as expressed in reality, damage or destroy the very person they love? Children struggle with intense feelings of love and hate, suffer guilt, and seek to make reparation. In good enough circumstances, parents can help their children manage these feelings and not become overwhelmed. But young children

can develop an overly critical or accusatory inner voice which can amplify and distort external admonishments, leading to excessive guilt or anxieties. Young children test out their capacity to love and to be loved in their encounters with others. It is, however, their capacity to establish and maintain good relations with a loved person within their internal world that forms the basis of the beginnings of independence and maturity. As children develop, they also need opportunities — to explore, to individuate, to learn, to form peer relations, to manage and to overcome fears and anxieties, to develop emotional strength and to have age appropriate experiences. Over time, with a developing sense of self, a sense of identity emerges — as a member of a family, as well as gender and ethnic identity. Language, ethnic and cultural issues are an important part of the experience of any child, and should be given due attention and thought.

New to CAMHS p69

The child's reality is not the same as the adult's, but it is easy to forget that when working with children and their families. Can you recall any misperceptions you had as a child, when your world and your reality were quite different from those of the adults around you? Record your thoughts and ideas, then compare your responses with the shadow learner below.

My aunt was visiting and kept saying, "I really must spend a penny". When she came out of the lavatory I asked if she would take me with her. "Where?" "Where you go to spend a penny." I remember the disapproving look she gave me, which baffled me - my aunt visited rarely, so to walk down to the shop with her was a treat. I suppose the term spend a penny was not used in my family.

Mum used to run a mail order catalogue for friends and neighbours. When she had returns to send back to the warehouse she would come into the room where we played and say distractedly "Where has my sealing wax gone". I knew she meant the dark red thing that looked a bit like a wax crayon, but as hard as I looked I could never see a trace of it on the ceiling.

Perhaps you remembered the same sense of bewilderment described by the shadow learner? Think about your dealings with children, including those you are working with now. Ponder whether there have been times when you failed to understand what the child was trying to communicate, then consider paying attention to non verbal cues, such as intensity of mood, facial expression, posture and orientation of the body.

The infant brain

The extract below provides a biological explanation for why children do not always apprehend the world in the same way as adults.

In-utero preparation for delivery involves pre-programmed behaviours of the baby. Similar pre-programmed behaviours are observable after birth, e.g. sucking and holding reflexes, and visual fixation and following behaviour. Although most of what happens before birth is subject to genetic control, intra-uterine experiences can also affect development, the best known of which are the effects of foetal exposure to alcohol which, in common with many drugs and some infections, can cross the placental barrier.

This means that children's earliest non-verbal experiences begin long before they gain any real ability to use language to communicate how they feel. Thinking and language require cortical development of the brain, which occurs quite late in brain development, but once developed it plays an increasingly important role in mediating experience. Environmental influences become increasingly important after birth, sometimes with irreversible effects. For example, sensory

deprivation in early infancy diminishes the growth of myelin sheaths and neural pathways. The earliest years of life are absolutely crucial for life-long mental well-being. Without early stimulation, stunting of neural pathways may occur, leading to irreversible stunting of affect and the child's future capacity to form relationships. Inadequate stimulation can occur for many reasons — for example, developmental studies have shown how maternal postnatal depression can diminish reciprocity in the mother-infant relationship, flattening their 'inter-subjectivity' (i.e. how attuned they are to one another). Brain imaging and neuropsychological studies have demonstrated a close relationship between brain structure and function, and the presence of 'critical periods' of development. This is the reason why, as a result of individual experience and developmental stage, children's experience of an apparently similar world can prove to be so different.

New to CAMHS p.50

Read Table 1 below for an overview of the major stages of brain development in children. If you are unfamiliar with the scientific language, use the links to go to simple explanations.

The table can also be found in the resources section for future reference.

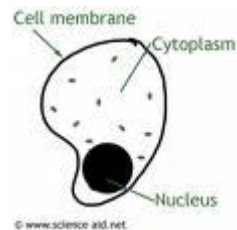
Table 1. Major stages of brain development in children. Please refer to the following page for explanations and diagrams.

Time	Neurones and developing brain structure	Growth of connections between neurones (dendrites)	Myelination of dendrites (production of insulating sheaths to maximise their connectivity)	Associated normal developmental outcomes	Effect of deprivation and reduced stimulation (see picture)
Conception to early infancy	Migration of cells (neurones) into new brain structures during foetal life.			1. Reflex-type movements develop. 2. Early affective experiences (limbic system).	
	The cortex is the last brain structure to develop.	Explosive growth from 28 weeks, maximum over next 7 weeks i.e. before birth (see diagram).	Begins during foetal life.		Inhibits myelination, stunting or flattening effect.
First four years of life	Brain weight quadruples over first four years of life. Much of this is cortex.	Continued growth of dendritic connections, until there is finally an excess compared with adult brains (in adolescence their number will become reduced).	Continues for four years after birth.	1. Early interpersonal growth. 2. Voluntary movements predominate over involuntary. 3. Acquisition of symbolic understanding and basis of all future language skills.	Inhibits myelination, with reduced learning potential
Later childhood and teenage years until early adulthood		Cortical pruning begins: the most-used local neuronal networks are preserved		1. Increasing ability to think in concepts 2. Surges of gonadalsteroids at puberty induce further changes in the limbic system, rapidly expanding the emotional attributions being applied to social stimuli, especially novel ones, and other pre-frontal functions.	Underdevelopment of neuronal networks involved in pre-frontal tasks results in reduced capacity for social judgement, impulse control and goal-directed behaviour

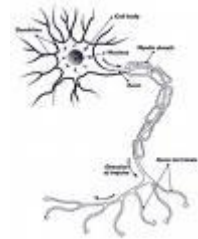
Explanations

Neurones.

Just another word for nerve cells. You are familiar with the appearance of simple cells in the body looking like this:

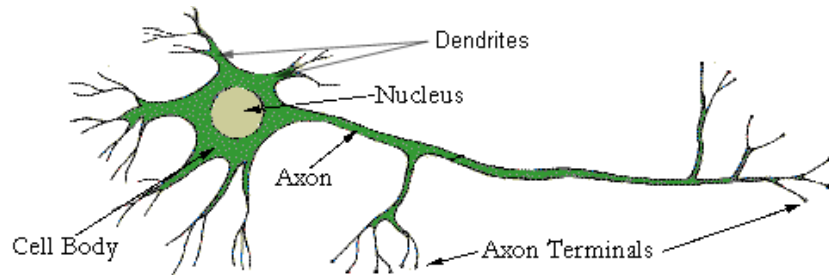


Nerve cells are highly specialised and are a different shape from simple cells:



Dendrites

These are the “branches” on the ends of the neurone. Dendrites conduct nerve impulses to the body of the cell by connecting to the dendrites of other neurones.



Myelin/myelination

The long trunk (axon) of the neurone is coated in a fatty substance called myelin, or the myelin sheath. The sheath protects the neurone and speeds up the nerve impulses.

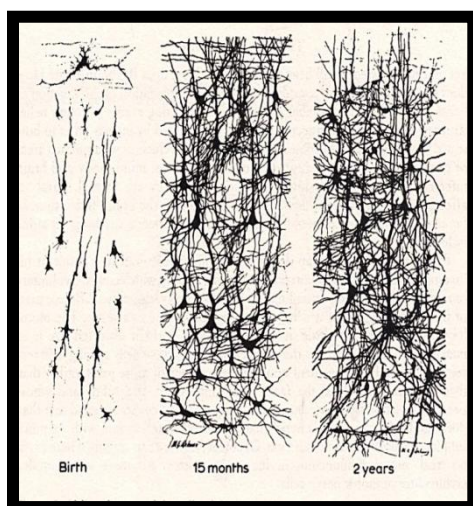
Limbic system

Part of the human brain involved in emotion, motivation, and emotional association with memory.

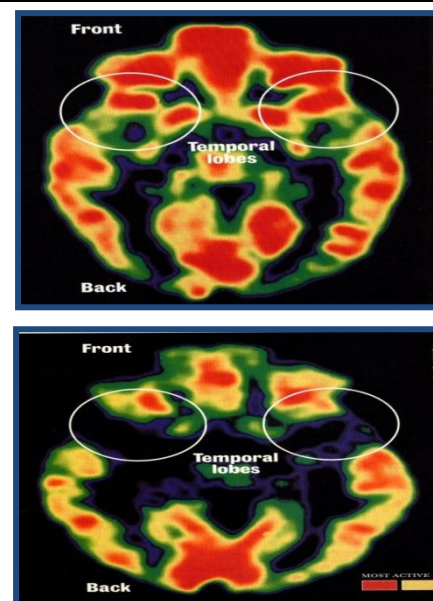
Cortex/cortical

This is the outer layer of the brain responsible for higher level processes such as sensation, voluntary muscle movement, thought, reasoning and memory.

Proliferation of nerve cell connections (synapses) in the first two years of life.



Comparison of infant brains: top, normal development, bottom, effects of deprivation



What we can learn or remind ourselves of is that the first years of life are critical for future functioning and are shaped by a complex inter-play between biological and environmental factors. Positive, caring, nurturing experiences enhance development and negative, neglectful and abusive experiences impede the child's growth; physical, intellectual, emotional and social. While children's brains are developing and they are making sense of the world around them, they often have a different perspective from that of adults. In a helping role we need to be sensitive to the inner world of the child.

Check your understanding so far by going to Self Test 1a on page 154. The correct answers can be found in the Solutions section




Attachment

The roots of research on attachment began with Freud's theories about love, but the researcher credited with formulating attachment theory is John Bowlby, who spent many years researching the concept of attachment, describing it as a "lasting psychological connectedness between human beings". This was the beginning of attachment theory, which holds that early experiences in childhood have a vital influence on development and behaviour later in life.

Bowlby proposed four distinguishing features of attachment:

Proximity Maintenance	Safe Haven	Secure Base	Separation Distress
The desire to be near the people we are attached to (i.e. for infants, the care giver).	Returning to the attachment figure for comfort and safety when we are afraid or threatened.	The attachment figure is a secure base from which the child can explore the surrounding environment.	Anxiety that occurs when the attachment figure is absent.

Bowlby's work was extended and refined by Mary Ainsworth. Based on her observations, Ainsworth concluded there were three major styles of attachment:

-  secure attachment,
-  ambivalent-insecure attachment,
-  avoidant-insecure attachment.

Later a fourth attachment style was added known as *disorganized-insecure attachment*. Many subsequent studies have supported Ainsworth's ideas and other theorists have extended attachment theory to adults.




Attachment styles

Secure

Children who are securely attached do not experience significant distress when separated from caregivers, although they prefer to be with their parents than with strangers. Securely attached children will seek comfort from the parent or care giver when they are frightened.

Ambivalent

Children who are ambivalently attached tend to:

-  be extremely suspicious of strangers
-  manifest considerable distress when separated from a parent or caregiver
-  not appear to be reassured or comforted by the return of the parent.

Avoidant

As the term suggests, children with avoidant attachment styles have a tendency tend to shun parents and caregivers and their avoidance may be particularly marked after a period of absence.

Disorganised

Again the clue is in the title, whereby children with a disorganised-insecure attachment style exhibit a mix of behaviours, including avoidance or resistance. They may appear confused and even dazed when with the care giver.

The ABC of attachment

Remember the ABC:

Attunement

Aligning the parent's own internal state with those of the child, often accomplished by the contingent sharing of non-verbal signals.

Balance

A child's attainment of balance of its body, emotions and states of mind through attunement with the parent.

Coherence

The sense of integration that is acquired by the child through its relationship with its parents in which the child is able to come to feel both internally integrated and interpersonally connected to others.

QUICKIE QUIZ

YOUR ANSWERS		
Name of original attachment theorist	J	B
Four distinguishing features of attachment	P	M
	S	H
	S	B
	S	D
Four styles of attachment	S	
	Am	
	Av	
	D	
ABC of attachment	A	
	B	
	C	

Look back to check your answers.



List the three most significant aspects of childhood you need to be aware of as a practitioner. Discuss with your supervisor or learning mentor.

Teenage years

“Like its politicians and its war, society has the teenagers it deserves”

Joseph Priestley
(1733-1804)
English Clergyman

Some facts and figures

Adolescents between the ages of 10 and 20 make up 13-15% of the total population of the UK and the proportion is considerably higher among black and minority ethnic (BME) communities, particularly those from Pakistani and Bengali groups. Unlike other age groups, mortality among adolescents did not fall significantly in the second half of the twentieth century. The main causes of death are accidents and self-harm, with a recent rise in suicide among young men (Royal College of Paediatrics and Child Health, 2003).

Ill health among teenagers is largely due to chronic disease and mental health problems and patterns of health behaviour and service usage during adult life are established in adolescence. Up to one in five adolescents may experience some form of psychological problem, ranging from behavioural disorders to depression, eating disorders, self-harm and neurosis. Mental health problems that develop in adolescence frequently persist into adulthood and may deteriorate over time. There is a strong association between mental health problems in adolescence and risk taking behaviour (British Medical Association, 2003).

Risk-taking may be defined as anything that could harm the young person's health and well being and includes the obvious categories such as substance mis/use, including alcohol and tobacco; sexual activity, especially early and unprotected sex; acting on impulse, such as crossing the road without looking; peer-influenced behaviour, such as driving too fast. But there is also risk in excessive consumption of sweets and sugary foods, leading a sedentary lifestyle, dieting and listening to very loud music. Young people often feel they are invincible.

Is there still a trace of the teenager in you? Think about the things you used to do in your teens – how do they strike you now? In your notebook create two columns. Take yourself back to being a teenager and in the left column make a list of the thoughts, feelings and behaviours you had at that time. Review what you have written by looking at those thoughts, feelings and behaviours as an adult; and in the right column jot down your responses and insights. Then compare your responses with the shadow learner below.

<i>As a teenager I....</i>	<i>As an adult I now...</i>
<i>Would never grow old</i>	<i>Look and feel my age, but still try to resist it</i>
<i>Would never act like my parents</i>	<i>Often act the way my parents did - and still can't quite believe I am doing it</i>
<i>Wanted to be adored</i>	<i>Have realised you have to love yourself in order for others to love you. Adored? Hmm</i>
<i>Rode motorbikes without a license</i>	<i>Would never take that sort of risk, but still dream about the freedom of riding a motorbike</i>
<i>Got drunk</i>	<i>Still sometimes drink too much, but worry about it more</i>

Were you so different then, or like the shadow learner are the changes in you more subtle and incremental; a slower process of maturation? For some adults, adolescents inhabit a different, incomprehensible world, but maybe teenagers are just like we were when we were young – and to be reminded is uncomfortable for us.

The adolescent brain

Having suggested that teenagers are perhaps only different from adults by degree, it is also the case that many experiences are more acute or intense during adolescence than at any other time of life. This may be caused partially by the continuing development of the frontal cortex of the brain, which is still changing during adolescence. This area of the brain is responsible for planning, choosing when and when not to act, controlling emotions and making decisions.

Brain imaging has shown that part of the frontal cortex is more active in teenagers than in adults when they are thinking about embarrassing situations, suggesting teenagers use their brains differently in social situations.

Researchers presenting at the Royal Society science exhibition (2009) have found that teenagers also behave differently to adults in social situations, being more influenced by their friends (peer pressure). When teenagers play driving simulation games, they take more risks in the presence of their peers than adults do. But when then teenagers play the game alone, their results are the same as for adults.

As well as being linked to brain development these differences in social behaviour and emotions are also related to changes in hormones during puberty.

Identity, body image and sexuality

This is a new stage in the life cycle of any family, with each member finding themselves in a different position in relation to each other. There may be a conflict within the young person between rebelling and conforming, between seeking new experiences and clinging to what is familiar, between accepting the challenge of increased responsibility and being dependent. More often than not, an adolescent may oscillate between these positions or respond to the same situation differently, depending on their state of mind. 'Going to the limit' may be one way of discovering what the limits are and what they are capable of managing. For all concerned, it can be a scary time, with parents and staff worried about a young person's safety or how their actions might impact on their future. At the same time, adolescence can also be a time of tremendous growth, achievement and creativity. A developing sense of self coincides with bodily changes and encompasses gender identity, sexual orientation and the potential for sexual relations.

Ethnic and cultural identity may be of particular importance to adolescents, in relation to both their families and their peer groups. Participation in peer groups can facilitate changes and provide a level of

safety, a 'psychosocial moratorium' as Erickson described it, which allows for some delay before the intimacy and commitment characteristic of adulthood. Being part of a group can "provide conjoint playground-cum-workshops concerned with identity where young people can find out, in conjunction with others, what it is like to be this changing, version of themselves: what interests them; whom they get on with, and why; how they experience their new sexuality". But some young people find themselves isolated, either not accepted by a peer group or unable to engage with others. It may be difficult for them to separate from their families, or they may be over-identified or enmeshed with their concerns. Others are reluctant to relinquish their childhoods, often withdrawing from the more active fray of adolescent activities. Still other adolescents become deeply troubled by the changes in their bodies that they cannot stop or control. For them, the onset of puberty isn't a welcome and longed for change, marking the start of a new developmental phase, but a catastrophe which threatens to disrupt their sense of self

New to CAMHS p 70

Most of us can remember the pain, embarrassment and, sometimes, wonder, at our unpredictable and changing bodies during teenage years. But for some young people body image can become a significant difficulty, linked to distorted self-perception and problems around eating and exercise. Sexuality and sexual orientation are central aspects of identity and sense of self; for those whose orientation is lesbian, gay, bisexual, or trans-sexual (LGBT) there are the additional issues around stigma and fear of exclusion.

The final report of the national CAMHS Review (2008, p 21) includes young people who are lesbian, gay or bisexual as vulnerable to mental health problems, including self harm, although stating there is as yet insufficient robust evidence. Whilst the evidence base is still developing, it nonetheless suggests that LGBT young people are at greater risk of self-harm, especially associated with experience of abuse and bullying (Bridget, 2007).

We are trying to understand, or remember, what it is to be a teenager in order that we can respond to them helpfully and sensitively. Many young people feel they are portrayed unfairly by negative media images and reports. Think about how you respond to teenagers and young people and what influences you.

Consider the following scenario and reflect honestly on how you would react.

You have been reading articles and hearing on news programmes for some time that bullying by teenage girls is increasing and has become a significant social problem.

You are on the last bus home and there is a group of teenage girls sitting behind you being very noisy. They are the only other passengers. The group becomes quieter and you hear someone crying and another girl sounding angry and swearing. You turn round and see three girls with their backs to you, surrounding another girl in the corner, though you can only see the top of her head, which is bowed.

What do you think? What do you feel? What do you do?

In your notebook record your thoughts, feelings and actions. Then compare your responses with the shadow learner below.

Something like this actually happened to me. My thoughts were: what are they up to, they have been drinking and they are all under age, they sound unpleasant, I hate to hear young people swearing. My first feeling was annoyance, then resentment that they were kind of invading my space and intruding on my thoughts. But then I felt worried and turned round. I did think the three girls were doing something nasty to the one in the corner. One large girl was angry and swearing, but she did not look round, so I said in a loud voice, "what do you think you are doing?"

The large girl turned to me and I realised she had also been crying. She said "Can you help us, my sister is diabetic and she has had too much to drink. We told her not to but her boyfriend finished with her. We are trying to keep her awake, but she looks like she is sleeping. I don't want her to die.

All adolescent behaviour happens within a context, which may be difficult for adults to comprehend. The Health Behaviour in School-aged Children (HBSC) study is cross-national research established 22 years ago in collaboration with the World Health Organisation (WHO) Regional Office for Europe. It aims to gain new insight into young people's health, wellbeing and health behaviour, including links with their social context. The latest available findings for England are from the 2001/2 study, published by the National Institute for Clinical Excellence (NICE) in 2006, stating,

One in five students (21%) report 'less than good' health, one in 10 (9%) say they are not happy and one in three (33%) report feeling low each week. Patterns of behaviour are generally similar for health, happiness and wellbeing. Generally, girls are more likely than boys to respond negatively to these measures. This difference increases with age; girls in year 11 are most likely to report 'less than good' health (32%), unhappiness (16%) and feeling low each week (44%).

The report finds a number of demographic and socio-economic variables have an impact on teenagers' reports of their health and well being.

Family wealth is an important factor, with *perceived* family wealth a stronger influence than the objective measures of family affluence.

Family social support and family sense of belonging has a significant impact on self reported happiness and well being and those with a low sense of belonging are more likely to give a negative response.

Low level support from teachers and parents at school has a negative effect on self-reported health and wellbeing, especially happiness. Those with a low sense of belonging at school are more likely to report low levels of health, feeling unhappy and feeling low.



Check your understanding so far by going to Self Test 1b on page155. The correct answers can be found in the Solutions section.



Reflect on the nature of adolescence. What is important for you to think about as a practitioner, in order to respond sensitively and appropriately to young people? Discuss with your supervisor or learning mentor.

The family context

“You need a whole community to raise a child.”

Toni Morrison 1971

American author and professor

Changes affecting the family

Social changes

Children are increasingly born outside marriage and sibships have become smaller, or women have chosen not to have children. Single parenthood is now common, as is divorce and re-marriage with the formation of new sibships. Mothers are more often in work, and adults who are in work are less likely to remain where they grew up, so parent friendship groups or neighbourhood supports are tending to replace the supporting role of extended family.

Changing mortality and morbidity

Nineteenth century public health measures and 20th century manufacturing innovation have greatly reduced both mortality and morbidity, but have also resulted in the loss of parents' 'jobs-for-life'. The much-reduced manufacturing/production costs of food and entertainment has resulted in surfeit, so childhood obesity and 'coach potato' (or 'Playstation') lifestyles are relatively new concerns.

Social adversity

The 'best', or the most favourable, effects of these developments have least helped families who experience the most social adversity; the current average age of death of an adult male in east Glasgow is still only 59 years. Community studies have demonstrated that adversity tends to be persistent, rather than episodic, and involves multiple stressors rather than single ones. No doubt, for these reasons, the ONS epidemiological studies of child mental health problems have demonstrated

very strong associations with social adversity, e.g. child mental health problems are at least doubled in households of more than five children, in reconstituted families or where there is a lone parent, where neither parent has educational qualifications, in low income families, where neither parent is working, in those living in council tenancies, and for social class V. However, as a recent review of Sure Start local programmes in the UK revealed, there is considerable cultural variation between disadvantaged or deprived communities, resulting in quite different implications for service delivery.

Information technology (IT) in the lives of children

A new phenomenon, this has brought considerable independence of communication, with family involvement perhaps mostly confined to paying for it. Mobile phones (especially text messaging) and net-based communication now play a major role in the lives of most young people, so that even living in a remote croft may now be associated with little involvement between parents and their teenager, but greater interaction with peers than might otherwise have been possible. Young people's IT access, including by the Web, can facilitate their access to much information and support they might otherwise have been quite unable to get. That can include easier communication with professionals involved in their care, which may be particularly useful in rural areas.

New to CAMHS pp54-5

The changing family structure

Despite the changes described above, the family is still the central element of modern life. Family structure in England, reflecting the wider society, has undergone significant changes since the middle of the last century. Many people regret these changes, imagining a halcyon past in which couples stayed married to each other and extended families lived in close proximity, offering care and support. The reality is that families have come in all shapes and sizes, across the ages, but also within different cultural groups; there is no ideal.

The Extended Family

The extended family refers to grandparents, aunts, uncles, and cousins. In societies with less social mobility and fewer working women, extended families can thrive because of time and proximity. As societies change and families move around more, extended families may become separated, although internet based communication might be a way of preserving those ties in the future. People living in extended families often have more informal support networks and may use services less than those in smaller or isolated units.

The Nuclear Family

The nuclear family is understood as parents and their children. These days this basic unit is typically small, comprising the two parents and an average of two children. The modern nuclear family however is still full of potential complications and diversity, all of which may affect the well being of its members.

Common variations

- Working Parents
- Single Parents
- Older Parents
- Much Older Siblings
- Younger Parents
- Stepfamilies

Try the quickie quiz to see whether you can discriminate between fact and fiction in family structures. The quiz is on page 156. The correct answers can be found in the Solutions section.

Parents

What is good parenting?







Think about either yourself as a parent or about your own parents or carers. What positive aspect of parenting has had a lasting effect on you? Write your reflections in your notebook, then compare your responses with the shadow learner below

I have chosen to think about my father, because he was not a very good parent and tended to be neglectful and sometimes cruel. However something he was good at, which gave me a lot of pleasure when it happened, was to tap into the world of a child. Sometimes he would say "come on kids, let's make toffee apples", (or whatever). Once he helped us construct a homemade slide and another time he made stilts. It was his enthusiasm that was infectious. Once when we were walking somewhere he took me to the edge of the canal, made me lie down flat and showed me how ants work together to build a home.

His ability to share in my world of wonder and experimentation stayed with me. I still get a lot of pleasure from exploring a rock pool, or making something out of nothing. You could call it resourcefulness. When I am with children I try to inhabit their world for a time and encourage them to be curious. I did the same with my own child and we both gained a huge amount of satisfaction from it.

The following list is based on work by the Royal College of Psychiatrists. Think about whether any of your reflections matches the items below. You will see the shadow learner was talking about "involving the child".

Good parenting

-  Consistency – mean what you say
-  Giving praise – show when you are pleased with your child
-  Having clear rules – and ensuring the child knows what they are
-  Involving the child – talking and doing together
-  Calmness – being firm rather than angry
-  Being realistic – not promising huge rewards or draconian punishments

Parenting is stressful and, it is a truism, but we do not receive any training for it. Parental stress has an impact upon children and may impede attachment. Causes of parental stress include:

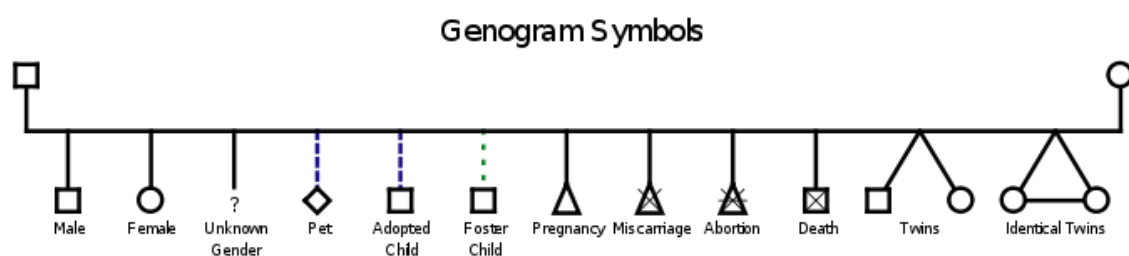
- 📖 Own experience of being parented
- 📖 Background of abuse, neglect or loss in childhood
- 📖 Low educational achievement
- 📖 Single teenage mother without family support
- 📖 Serious medical condition
- 📖 Severe mental illness
- 📖 Recent life stress (e.g. bereavement, job loss, immigration)
- 📖 Own mother mentally ill/substance abused
- 📖 Criminal or young offender's record
- 📖 Previous child in foster care or adopted
- 📖 Mother has experienced loss of a child
- 📖 Alcohol and/or drug abuse

Parents and parenting are a major influence on the nature of a family and the child's experience within it, but many other factors also have an impact, including:

- 📖 Number and age of siblings
- 📖 Position of each child within the family
- 📖 Illness or disability among any of the family members
- 📖 Family moves – to new home, new area, or different country

You may already be familiar with genograms – a way of representing in a diagram the important family and close relationships in an individual's life. Genograms are an important tool for practitioners in CAMHS, in depicting emotional relationships and possible conflicts within the family. Using a genogram can also help the practitioner think with the young person about their support networks. A genogram can be very simply a network of connecting lines between important people in that individual's life, but by including more detail and symbols, it can incorporate quite complex patterns and histories.

Some professional groups have their own specific symbols for creating a complex genogram. The ones provided below are an example.



The box below describes the family relationships for Dulcie-Kate. Plot the relationships in a genogram using the symbols above, your own symbols if you already use some, or a design of your own making.

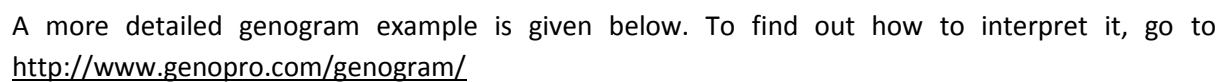
Create the genogram in your notebook, then go to the shadow learner below for some extra information.

Dulcie was born in 1998 to a White British mother and father whose Kenyan-Indian parents had migrated to Britain in 1975. In 2004 Dulcie's parents separated and subsequently divorced. Dulcie lives with her mother and sees her father every weekend, in their old family home in the next county (England). Mum's family live close by and Dulcie has contact with (maternal) Aunty Nicola and Uncle Dave and their children Sam and Karen, aged 11 and 8. Dulcie also sees (maternal) Uncle Tim and his wife Sarah, who have no children of their own, but are very fond of Dulcie. Dulcie had a cat, Thomas, from the age of two, but the cat died this year. Dulcie's maternal grandparents live and run a B&B in North Wales and she sees them about three times a year, though feels very close to them. Dulcie's paternal grandmother lives in central London with an aunt, but the grandfather died soon after Dulcie was born. All other family members emigrated to Canada and Dulcie has visited once with her dad. Dulcie has a best friend who lives across the road, called Rajinder. She also really likes the older woman who runs the newsagent on the corner of the street and stops there most days after school for a chat and helping to stock the sweetie shelves.

Dulcie is my own child. Sketching out this basic genogram was very helpful in thinking about the effects of family movements and migration, the ruptures in families caused by migration, separation, death and divorce.

But it was also helpful in looking at the importance of family and social networks and gave me ideas for helping Dulcie think about her identity as a mixed heritage child.

I produced the genogram below with Dulcie's help - it is a little unconventional.





Working in specialist CAMHS involves working with the whole family and being aware of the wider familial and social networks that are important to the child or young person.

We need to understand the pressures on families and the potentials within them so that we can help children and young people develop their own coping mechanisms and support structures.

What have you taken away from this section? Jot down your thoughts and pick them up with your supervisor or learning mentor.

Sensitive and effective working

“A smile is the universal welcome.”

Max Eastman
(1883-1969)
American writer

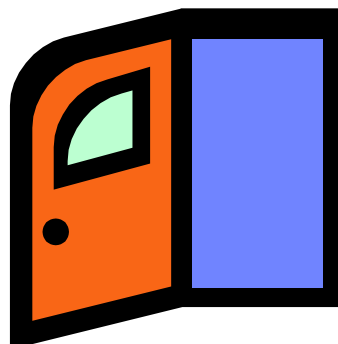
The environment of care

The settings in which children, young people and families receive support for mental health and emotional well being are varied and in most areas no longer confined to hospitals and clinics. Now it is far more common to use friendly and familiar locations such as children’s centres, schools and other non-clinical settings within communities. Sometimes hospitals and clinics are used and if this is the preference of those using the service it is perfectly acceptable.

All service locations should be made as welcoming as possible, catering for different ages and diverse cultures, making every visitor feel comfortable. Unfortunately this is not always the case.

How do children, young people and their families feel when they arrive at a service location? Does the environment help them feel less worried or does it actually create anxiety?

New to CAMHS?



Come in.....

There is a slideshow available on the CD ‘New to CAMHS?, then come back to this workbook.





Using the slideshow to jog your memory, write a couple of brief paragraphs about your first experience of arriving at your CAMHS base. Then compare your responses with the shadow learner below.

Before the days of sat nav, I was driving around the area for what seemed like hours. Luckily I was early on my first day. I stopped and asked a few people but they had never heard of the "Health Care Village". Later I discovered it was known locally as the mental home. Nobody had warned me about parking - the car park was full so I had to go on to a side street, going out to feed the meter every couple of hours all day.

When I got into the building there was no Reception, so eventually I was directed by someone to the fourth floor where a lovely woman greeted me, but clearly had no idea who I was.

I felt flustered, frustrated and apprehensive by this stage - and my first day had not even begun.

How can you use your experience to ensure the children, young people and families who arrive to see you:

-  are able to get to you without too much difficulty;
-  know where to go on arrival;
-  are welcomed when they arrive;
-  feel comfortable in the surroundings.

Record some points in your notebook to remind yourself of ways to ensure your setting is accessible and welcoming.

In the Resources section you will find a *Welcome Checklist* for future use.

A further consideration is that young people often complain that the buildings they attend for help and support often cater more for younger children, reflected in toys, books, furnishings and decor. Think about what can be done to make the waiting area for your service appropriate for a range of age groups.

Cultural competence

Being welcoming, attuning yourself to and empathising with the needs of your clients are all part of a broader approach to be culturally sensitive. Responding sensitively to others regardless of their background applies as much to their age, gender and sexual orientation as it does to their ethnicity, faith or belief systems. The concept of culture embraces customs, beliefs, values and way of life and cultural competence means being able to work effectively with those who do not necessarily share our own cultural values and behaviours.

A commonly quoted definition of culture is from Chamberlain (2005, p. 197),

the values, norms, and traditions that affect how individuals of a particular group perceive, think, interact, behave, and make judgments about their world.

Cultural competence has been promoted in the United States for many years, where in many states cultural competence training is mandatory. A widely used description of cultural competence applied in the US is:

A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

(Cross et al, 1989)

Cross et al also proposed a continuum, which was originally designed to assess an organisation's level of cultural competence, but has been adapted below to help you think about your own level as a practitioner.

Competence level	Practitioner characteristics
Cultural proficiency (Advanced competence)	<p>Holds culture in high esteem.</p> <p>Adds to knowledge base by doing research, developing new approaches based on culture, publishing results of demonstration projects.</p> <p>Seeks advice and supervision from specialists in culturally competent practice.</p> <p>Advocates for competence throughout the system.</p>
Cultural competency (Basic competence)	<p>Has acceptance and respect for differences.</p> <p>Engages in continuing self-assessment regarding culture.</p> <p>Makes adaptations to service models in order to meet client needs.</p> <p>Seeks advice and consultation from minority communities.</p>
Cultural pre-competence	<p>Appreciates own weaknesses in serving minorities and attempts to make specific improvements.</p> <p>Tries experiments; explores how to reach clients, seeks training on cultural sensitivity, recruits minorities for boards and advisory committees.</p> <p>Has commitment to human rights.</p> <p>May feel a false sense of accomplishment that prevents further action.</p> <p>May engage in tokenism.</p>
Cultural blindness	<p>Believes that colour or culture make no difference; we're all the same.</p> <p>Believes helping approaches used by dominant culture are universally acceptable and universally applicable.</p> <p>Thinks all people should be served with equal effectiveness.</p> <p>Ignores cultural strengths and blames clients for their problems.</p> <p>Follows cultural deprivation model (problems are the result of inadequate cultural resources).</p>
Cultural incapacity	<p>Takes paternal attitude toward "lesser" groups and communities.</p> <p>Discriminates based on whether clients "know their place" and believes in the supremacy of dominant culture helpers.</p> <p>May support segregation as a desirable policy.</p> <p>Gives subtle "not welcome" messages.</p> <p>Has lower expectations of minority clients.</p>
Cultural destructiveness	<p>Holds attitudes, beliefs and practices that are intentionally destructive to a cultural group.</p>

Where would you place yourself on the scale above? Think about your practice not just in relation to Black and ethnic minority communities, but to a range of other minority or potentially excluded groups. For example, consider how you respond to elderly people, travellers, refugees, those who are long term unemployed, or with a learning disability. In your notebook record your thoughts, feelings and actions. Then compare your responses with the shadow learner below.

I probably consider myself to be culturally competent and in work I strive to be so. But I am aware of inconsistencies between my private and professional worlds. For example when driving behind a slow vehicle I may say or think "Bound to be a wrinkle". I also often refer to things I disagree with as "bonkers", "loopy" and "insane".

When I say these things I am not aware of inner feelings of superiority over others, nor any desire to offend. But am I any better than someone who uses words that I find repulsive such as "Paki"?

Or is it that we all feel justified in our own words and behaviour, rather than taking the trouble to find out whether we are in fact being offensive?

I suppose I am still on the journey.....

Over the last thirty years or so a number of different pieces of equality and equality-related legislation have been passed in the UK. During that period it has become clear that equality legislation can be a minefield of misunderstandings. It seems the greater the efforts to be precise, the more chance that a group will find itself to have been excluded or overlooked. On the one hand there is scepticism in some quarters about political correctness, on the other the greater the efforts in specifying which groups are to be socially included, the higher the chance of being charged with selectiveness or tokenism.

The latest government response to these issues is the Equality Bill, which should become law in 2010. The new Bill introduces the key description "protected characteristics", including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief (including lack of belief), sex, and sexual orientation. The law is intended to protect men as well as women; and heterosexuals as well as gay people, where necessary.

Go to the Self Test 1d on page 157 to consider a set of statements that are reflective of the different levels of cultural competence. Suggested answers can be found in the Solutions section.

Some of the statements may have prompted a reaction in you. Jot your thoughts down and discuss with your learning mentor or a trusted colleague.

Case Study – Kieran

0 – 5 years

Kieran was born to his mother Sarah and father Tony. He was their second child, having an older sister Maeve. Kieran's parents live in a moderately well-off middle class neighbourhood in a suburb of a large city. Sarah had a difficult pregnancy with Kieran who she described as 'a pain waiting to be born'. She was often in distress particularly during the second and third trimester, necessitating two hospital stays. The reasons for the discomfort were never clearly identified.

The midwife reported in the notes that Sarah has lost quite a bit of weight during the pregnancy and it was confirmed that her nutritional intake was poor throughout the nine months. Sarah stated that she "just did not feel like eating".

It was rare for Tony to be seen together by Midwives and Health Visitors as he was always 'at work'. He never took up any offers to accompany Sarah and meet with healthcare personnel. (*See following health visitor notes.*)

At pre-school Kieran was unpopular with other children and often played alone. Sarah noted that she had to apologise to other parents over Kieran's physical abuse of other children. Sarah reported to a Health Visitor that "his dad thinks it is just high spirits and he'll grow out of it".








Following a routine GP visit, a referral was made to a Play Therapist. During the assessment session, the therapist noted that Kieran was eager to engage in casual violence with toys. In play scenarios there was rarely a father figure. When asked this, he just replied "I like me Mammy".

However the therapist was uncertain that there was much call for follow-up work and Kieran and the family were not offered a service.

Your notes and queries...



Issues/potential problems

What issues does the above raise for you in respect of:

-  Antenatal and perinatal care – picking up on signs of possible difficulties
-  Parenting – different styles and approaches, conflict/disagreement between parents
-  The parents' relationship and its impact on the whole family
-  Maeve- the older sibling, importance of position in family
-  Family structure
-  Impact of social change upon this family
-  The development of attachment and any threats or compromises to secure attachment

Skills

If you were consulting to primary care staff such as health visitor, Children's Centre worker, nursery nurse, etc, what advice, as a specialist mental health professional, would you give in respect of:

-  Engaging with the whole family, individually and/or together to promote emotional well being
-  Using observation, empathy and active listening to be aware of any potential behaviour/emotional difficulty as early as possible

Write your ideas in your notebook and discuss with your learning mentor or a trusted colleague.

CHILD'S NAME <i>KIERAN MCCARTHY</i>		
DoB <i>11-7-90</i>	ID (affix label)	
FAMILY ASSESSMENT		
DATE: <i>20-1-92</i>	NAME OF PROFESSIONAL AND VENUE: <i>S. SMITH. CLINIC</i>	SIGNATURE <i>[Signature]</i>
DESCRIPTION OF VISIT – (new birth/follow up plan etc.) <i>Follow up - mother request</i>		
CHILD/REN DEVELOPMENT: include recent or chronic illness, growth and development, diet and the child's emotional and behavioural state. <i>Keira 18 mth. Dev. normal - milestones ✓ Behaviour: restless & energetic (too energetic?) Appears hyperactive at times, displays poor concentration. Good health. Well fed. dressed.</i>		
PARENTING CAPACITY: look at the constituent parts of good-enough parenting, which range from Basic Care and Ensuring Safety, which is most relevant to younger children, through to Guidance and Boundaries, which includes parental modelling and guidance as the young person matures. Include parental mental ill-health and substance misuse. <i>Dad was not at home - at work. Works long hours. Mum has 'little control' over Keira, finds him "a handful".</i>		
FAMILY AND ENVIRONMENT: look at all the external factors that impact on family life. Includes the influence of family history and relationships within the family, the family's social interaction and what social networks they have <i>Family lives in Ireland. Few family networks here. Potentially difficulties in the marriage - dad absent for long periods, disagrees with mum over parenting, tends to be "strict".</i>		

References

Ainsworth, M. 1). S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Hillsdale, NJ: Erlbaum.

Blakemore, S.J., Dumontheil, I., Cook, J., Sebastian, C., Burnett, S., Houlton, R., Hulme, O., Hillebrandt, H., Choudhury, S., & Bird, G. (2009) *The teenage brain – a work in progress Using cognitive neuroscience to understand adolescent development*
<http://www.summerscience.org.uk/09/sites/default/files/factsheets/15.The%20teenage%20brain.pdf>

Bowlby, J. (1982). *Attachment and loss. Vol. 1: Attachment* (2nd Ed.). New York: Basic Books (new printing, 1999, with a foreword by Allan N. Schore; originally published in 1969).

Jan Bridget, J., (2007) *Lesbian, Gay and Bisexual Young People: Evidence-based Services and Resources*
<http://www.cypf.csip.org.uk/silo/files/lesbian-gay-and-bisexual-young-people--evidencebased-services-and-resources.pdf>

British Medical Association (2003) *Adolescent health*. BMA publications
[http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFAdolescentHealth/\\$FILE/Adhealth.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFAdolescentHealth/$FILE/Adhealth.pdf)

Chamberlain, S. P. (2005). Recognizing and responding to cultural differences in the education of culturally and linguistically diverse learners. *Intervention in School & Clinic*, 40(4), 195-211.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care*, Volume 1. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center

Department for Children, Schools and Families (2008) *Children and young people in mind: the final report of the national CAMHS Review*
<http://www.dcsf.gov.uk/CAMHSreview/>

National Institute for Clinical Excellence (2006) *Health and social inequalities in English adolescents: exploring the importance of school, family and neighbourhood*.

D L Quinton, D.L., Pollock, S. B., & Golding, J., (2002) *The Transition to Fatherhood in Young Men: influences on commitment*. University of Bristol
<http://www.fatherhoodinstitute.org/index.php?id=13&clD=477>

Royal College of Paediatrics and Child Health (2003) *Bridging the Gaps Health Care for Adolescents* London: Royal College of Psychiatrists Council Report CR114
<http://pb.rcpsych.org/cgi/reprint/27/10/397>

Royal College of Psychiatrists. *Factsheet: Good Parenting: information for parents, carers and anyone who works with young people*
<http://www.rcpsych.ac.uk/mentalhealthinfoforall/mentalhealthandgrowingup/goodparenting.aspx>

Positive mental health and promotion

“People are scared of talking about emotions – I mean adults here”

Child at a YoungMinds children’s conference






2005

The World Health Organisation definition of mental health, which has been adopted by leading mental health organisations, states:

A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

The WHO definition is very broad and in applying it to children and young people the concepts have been described more fully. Consider the following extracts, the first from NHS Advisory Service (1995) review of Child and Adolescent Mental Health Services: 'Together We Stand'.

Children with good mental health have:

-  *a capacity to enter into and sustain mutually satisfying personal relationships*
-  *a continuing progression of psychological development*
-  *an ability to play and learn so that attainments are appropriate for age and intellectual level*
-  *a developing sense of right and wrong*
-  *a degree of psychological distress and maladaptive behaviour that is within normal limits for the child's age and context.*








Being mentally well is not necessarily the same as always being happy, but can sometimes be about the ability to cope with unhappiness.

CAMHS REVIEW Key recommendation: The delivery of early intervention work in universal services should be supported through additional training, formal supervision and access to consultation from specialist services.

(p.13)

Kay (1999) Bright Futures, Promoting children and young people's mental health

Children who are mentally healthy have been defined as having the ability to:

-  *develop psychologically, emotionally, intellectually and spiritually;*
-  *initiate, develop and sustain mutually satisfying personal relationships;*
-  *use and enjoy solitude;*
-  *become aware of others and empathise with them;*
-  *play and learn;*
-  *develop a sense of right and wrong; and*
-  *resolve (face) problems and setbacks and learn from them.*

The ability to deal with difficulty is given as a feature of positive mental health. Supporting children and young people in their potential to develop this resilience is part of adopting a health promoting approach.




The importance of (positive) mental health

The importance of ensuring positive mental health for children and young people is supported by a raft of evidence and this evidence base underpins recent national policy. The National Service Framework for Children, Young people and Maternity Services (DH, DfES 2004) states:

The importance of psychological well-being in children and young people, for their healthy emotional, social, physical, cognitive and educational development, is well-recognised. There is now increasing evidence of the effectiveness of interventions to improve children's and young people's resilience, promote mental health and treat mental health problems and disorders, including children and young people with severe disorders who may need admission.

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

The CAMHS Review (2008) asked children what 'made them feel good inside' and asked young people what things they thought were important for children and young people's well-being. The answers, below, were consistent with other studies involving children and young people:

-  *having good support networks - across family, friends and school*
-  *being able to do things they enjoy - ranging from sports and community based activities, to having time with family and friends, and time to relax*
-  *building self-esteem - in particular by having their achievements recognised and by having goals to work towards.*

Reflect on what young people have said – is it very different to what you would have said? How did it feel at a time when you experienced a difficulty, or were very stressed and what effects did it have on you and/or your family? In your notebook record what helped you to overcome the difficulty and what resources did you were able to call upon. Then compare your responses with the shadow learner below.

When I became ill a few years ago the most stressful part was worrying about taking time off work, as I had not been there long enough to qualify for sick pay. My family depended on my income but I didn't want to cause them any more worry.




What helped me was being informed about my options and making sure I understood the treatment, how long it would take to recover and, most important of all, the things I could do myself to speed up my recovery. Sometimes the last thing you feel like doing is physical exercise, but if others coax and cajole you, it is definitely worth it. My partner came on walks with me which really made me feel better.







I received lots of messages of support from friends, which made me feel I was cared for and I think helped me a lot.

Emotional health is about the way we think and feel, and the ability to cope with difficult things in life. If something happens and we feel low emotionally, getting back on track can be difficult. Good emotional health is important for young people as they have to make choices about studying, careers and other areas of their lives. At the same time, young people are also developing greater independence and responsibilities, and experiencing changes in the way they think and feel. Many young people have strong coping strategies and are generally resilient to these challenges, but some will need additional help to develop resilience and stay emotionally healthy.

Being emotionally healthy










Encouraging, supporting and providing opportunities in the following areas may help:

-  Talking about things which worry them
-  Highlighting their strengths to increase self-esteem and confidence
-  Supporting them on things they find difficult and helping them to develop personal coping strategies

-  A healthy lifestyle with a balanced diet, plenty of sleep and regular exercise
-  Time for relaxation and doing things they enjoy
-  Spending time with friends and family
-  Providing information on sources of help and support and how these can be accessed.
-  Young people generally are able to cope well with stress on a daily basis and also with difficult life events.
-  Building on existing skills to develop self-esteem and confidence in their abilities and also building strong networks of social support are key in enabling young people to develop resilience and stay emotionally healthy.

Among the opportunities and independence which young people experience, there are challenges, key choices, new experiences and difficult life events.

As their resilience is tested, young people may show some of the following warning signs of poor emotional health:

-  Lacking energy or appearing particularly tired
-  Appearing more tearful
-  Not wanting to talk or be with people
-  Not wanting to do things they usually enjoy
-  Eating, drinking or sleeping more or less than usual
-  Using alcohol or drugs to cope with feelings
-  Finding it hard to cope with everyday things
-  Appearing restless and agitated
-  Not liking or taking care of themselves or feeling they don't matter

These are some of the signs that parents and carers as well as young people themselves, will have recognised and caused them to consult a health professional. But although warning signs may go some way to identify young people with poor emotional health, emotional distress and despair are not always observable.

The role of specialist CAMHS in mental health promotion

The three Ps

It is important to differentiate between the ways of promoting positive health.

Protection

Immunisation is typical of a protection strategy. Programmes to immunise the population against diseases such as measles, mumps, diphtheria, are long standing and well known, sometimes contentious. Protection against mental health problems might be better understood as strengthening the resilience of whole populations, say through social or health policy.

Prevention




A programme that includes advice and guidance about relationships and contraception is aiming to avoid unwanted/unplanned pregnancy. This is a prevention strategy. Prevention often targets groups that are known to be at increased risk, or vulnerable. Much of the focus of children's policy in recent times has been on the prevention of mental health and emotional difficulties, expressed through programmes such as SureStart (Children's Centres).

Promotion










Getting a promotion at work means being moved up to a better job, or having improved career prospects. Similarly health promotion refers to encouraging, enhancing, supporting and enabling improved prospects for people's well being. Promotion of mental health and emotional well being is implemented through initiatives such as Healthy Schools, a whole school approach that includes social, emotional and cognitive aspects to create an environment in which emotional well being can be fostered.

Promoting mental health is not just the job of health promoters, or staff in universal children's services. Emotional well being and developing resilience and coping strategies are relevant for young people even when they also have a mental health problem, disorder or mental illness. Prevention and early intervention can apply equally to all young people, whatever their existing state of mental health.

Three levels

-  Primary prevention entails taking measures to stop a health problem from ever beginning. Typically this could include perinatal and infant health programmes that promote secure attachment.
-  Secondary prevention involves the early detection of a problem followed by a swift intervention to halt its progress. Primary Mental Health Workers (PMHW) use this approach, identifying potential problems and difficulties early, working with parents, child health and schools, to prevent escalation.
-  Tertiary prevention means working with an existing problem to avoid it becoming chronic and/or reaching crisis point. All children and young people referred to specialist CAMHS will benefit from prevention of their problems reaching crisis, or, if the crisis has occurred, in being helped to prevent recurrence. Support that acknowledges a young person's existing skills and strengths will equip them better to develop their own coping strategies.

What works?

-  Parenting education and skills e.g. via Children's Centres for those caring for young children and adolescents, including foster parents and residential care workers, for general population and high risk groups - address maternal mental health;
-  Ensure fathers are included;
-  Violence and abuse prevention skills for self-protection, ability to deal with conflict, and promotion of respectful relationships;
-  Emotional Literacy: adoption of Social and Emotional Aspects of Learning in primary schools. Pilots in secondary schools underway. Pre-school being developed.
-  Access to arts and creativity which promote positive emotions and a sense of well-being;
-  Healthy whole school approach to ensure mental health promotion and violence and abuse prevention programmes (including bullying) underpin Healthy Schools curriculum for Sex and Relationship Education, PHSE, citizenship, including substance misuse and sexual health;
-  Appropriate and accessible CAMHS services-ensure services across the tiers are appropriate to local need and well integrated;
-  Appropriate referral criteria to prioritise high risk groups. Support schools and health professionals in identifying, managing and referring emotional and conduct disorders;
-  Access to youth friendly services ensure children and young people have the skills and information of how and where to seek support and information for issues surrounding abuse and mental health. (Shribman & Bullingham, 2008)

Think about holistic approaches such as Emotional Literacy programmes and Healthy Schools. These are aimed at creating environments in which all children and young people can thrive – enjoy, achieve, be safe and healthy and participate. In your own setting, your CAMHS base, clinic, or unit, consider how it could be made into a mental health promoting environment. Write your ideas your notebook. Then compare your responses with the checklist in the resources section.

As you have seen from the checklist the health promoting CAMHS is a holistic concept, including aspects of the whole organisation, the workforce and the physical environment, as well as factors connected with users of the service. If your own well being is not being promoted, it is unlikely you can be of much help in promoting the well being of others.

Check your understanding so far by going to Self Test 2a on page 158. The correct answers can be found in the Solutions section.

Theories and approaches – social and psychosocial ways of thinking about mental health

“Generally, the theories we believe we call facts, and the facts we disbelieve we call theories.”

Felix Solomon Cohen (1907-1953)
American lawyer and scholar

Children and young people are referred to specialist CAMHS because another professional from children’s services believes they have mental health problems that require specialised help which is beyond the support and care provided by universal services.

When the referral is accepted by specialist CAMHS it will be allocated to the professional(s) with the knowledge and skills that are most fitted to meet the needs. The ways in which this allocation is performed are many and various and within the team there will be a range of held views and perspectives about the origins and causes of mental health problems. Part of the purpose of a multidisciplinary team is to use these different perspectives to enable multiple understandings and promote a holistic approach to helping.

You may already be familiar with the perspectives in the diagram below. [Link](#) for more information to those you are less familiar with, or just scroll down through the following pages to learn about all of them.

Social and psycho-social perspectives Key concepts: social factors: race, culture, deprivation, gender; psycho-social aspects of experience in interacting with the environment.		Biological perspectives Key concepts: genetic vulnerability mediated by environmental factors.
	Family and systemic perspectives Key concepts: the family as a system within other systems, the whole is greater than the sum of its parts, homeostasis.	
Psychodynamic perspectives Key concepts: attachment, transference and counter transference, containment.		Cognitive and behavioural perspectives Key concepts: Core beliefs, automatic thoughts, reframing alternatives, testing.

A social model of health focuses on the environment as the main cause of poor mental health. Social factors, such as poverty, isolation, poor housing, race, and gender, all affect health, including mental health. For example, a strong association has been found between mental disorder in children and young people and family income and social class. A social model also takes account of cultural and ethnic factors. The family, as the smallest social unit, is affected by social trends. The proportion of families comprising a couple with their children is decreasing while the number of lone parent families is increasing. One child in four is brought up in a lone-parent family. Lone parent families are more at risk of socio-economic disadvantage. They are usually headed by women, who themselves have poorer mental health than men. Families tend to depend on two incomes, which means divorce has a strong economic impact on them. When they divorce, women who are mothers are on their own for an average of four years at a time. Almost half of women with children under five are now in employment, although mainly in part-time employment.

In the 1990s, the cost of having a child was evaluated at around £3,000 a year. This cost is borne by women more than it is by men. The cost of having a child has been estimated to diminish a woman's lifetime earnings and pension by two thirds. If our society attended to socio-economic disadvantage (instead of letting the gap between rich and poor widen) and social exclusion (of disadvantaged and minority groups), the rate of mental health problems in children would improve substantially.

A psychosocial model remains focused on the environment but is more embedded into people's own lives and interpersonal context. An assessment of children and young people's well-being has to include their emotional environment, and the kind of care-givers they have and the relationships they have developed with them. For older children, this involves the school and the peer group. Factors like abuse and neglect, bullying, and less visible interpersonal difficulties — none of which are specific to economically disadvantaged households — are detrimental to mental health.

New to CAMHS pp93-4

Why do you think poverty, race or gender affect mental health? Think of three young people you have encountered in your work in which one of these factors played a part. Record your reflections in your notebook and discuss with your learning mentor or supervisor

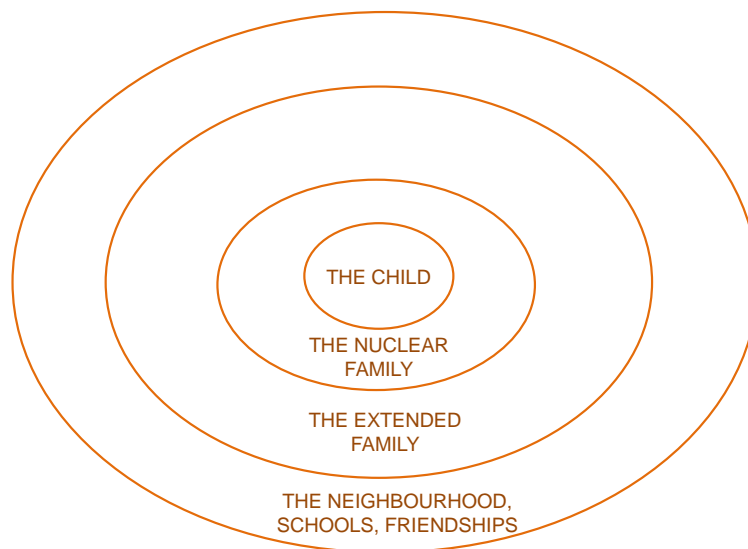
From before they are born, the family contexts of children differ. Some are embedded within stable communities, perhaps with grandparents and extended family members, while others have experienced increasing or sudden changes in their circumstances (possibly through migration or having to seek refuge. Culture influences the way a family develops, e.g. a family from an ethnic minority may have different factors affecting its development. The main point is that all influences are taken account of. Some families live at the heart of their communities, whether traditional or evolved, while others experience social exclusion and fall back on their own meagre resources. This impacts upon children directly, or through the well-being of their parents whose central role is to provide them with a context of relationships to develop and thrive.

All the models which offer ways of understanding young people's mental health needs are compatible with a family approach. Family therapists have demonstrated and argued that a systemic assessment is always beneficial.

Systemic thinking makes it possible to map a child's links to the groups (or systems) to which she belongs, like a series of concentric circles (see drawing below): her nuclear and extended family, her community/neighbourhood/school, her friends and the wider social, cultural and economic network. The only issue that varies from child to child is the weight to be placed upon family and systemic factors, and how far to include family members in treatment.

New to CAMHS p. 97

The systems in a child's life



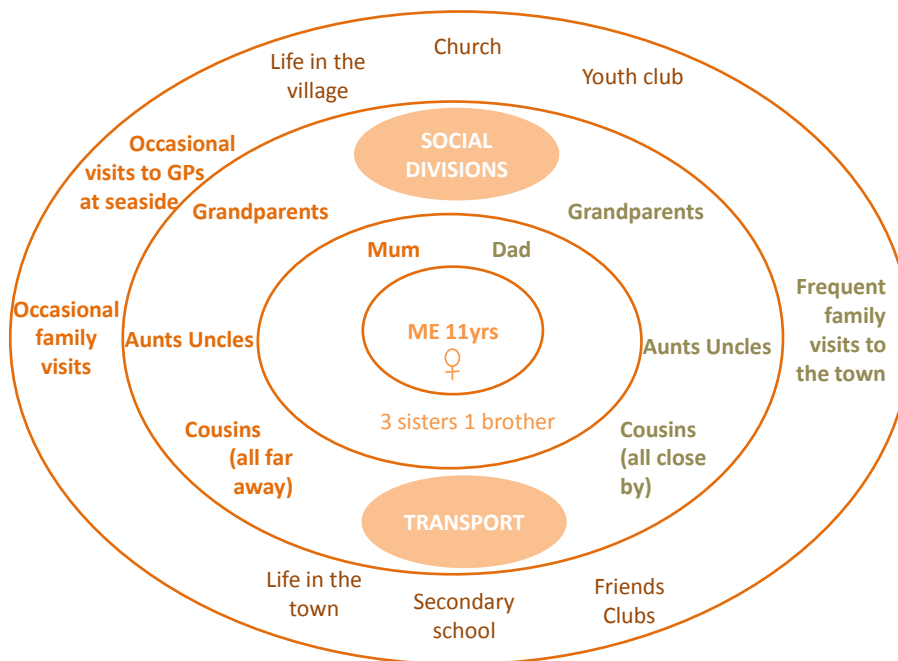
Remember your own family when you were a child. What sort of family structure did you have, how did you experience your relationships with other relatives and friends and what were the important aspects of your environment?

Draw the above diagram in your notebook and record your memories of these structures and systems. To see the shadow learner's animated diagram, open the slideshow on the CD 'Systems in a child's life' and compare with your responses. There is more detail from the shadow learner

The diagram below shows my social and family systems at age 11. I have highlighted the two most significant factors as I recall them. The first was the reliance on transport to maintain networks. We lived in a village and my paternal relations were in the town 3 miles away - we could walk, get a bus, or sometimes a lift in a car. But the other side of my family was dispersed and it was much more difficult to see them on a regular basis. People did not use the phone so much in those days.

The second significant aspect was that I passed the 11 plus and went to school in the town, losing most of my previous friendships in the village. I made new friends and joined clubs, but the village life I had known became more and more closed off to me. I needed transport more than ever to see friends and go to events in the town and beyond.

below.



The whole is more than the sum of the parts

This is a key idea. The sum of the parts in a family – the sum of members’ individual characteristics – gives an inadequate understanding of what constitutes a family. It is the matrix of relationships that individuals form, or find themselves in, that may be the key to individual functioning and well-being. This is also true of other social systems (for example clinical teams). Family dynamics can be helpful or unhelpful to an individual family member: talents can go unrecognised or under-utilised, an individual child can become the carrier of the family’s grief, vulnerability, anger, etc.

Conversely, family support and strength can get individuals through difficult periods in their lives. Therefore the family can bring risk factors into a child’s life (for example insecure attachment, inconsistent discipline, chaotic organisation) or protective factors (secure attachment, clear communication, supportive interactions) – for further elaboration of this, see Carr 2006 p66 and Rutter 1998]. For this reason, it is essential to understand the emotional climate of families.

New to CAMHS p.97

Just think about how you would describe the emotional climate of your childhood family. Is that how outsiders would have perceived it? Recall another family you knew – how did the emotional climate of that family compare with yours? No need to record unless you want to, but continue to ponder.

Homeostasis

This has been, and continues to be, an influential concept in systemic thinking, yet it is by no means original. 'Homeostasis' simply means the tendency of a system (whether mechanical, biological, social, or psychological) to assume a steady position and to revert to it quickly after the position has been disturbed (the surface of a pond settling after a fish came up to catch a fly; re-growth correcting asymmetry after a plant was pruned; new ideas introduced to a professional group quickly forgotten in favour of well-established ways of working).

Families may struggle to overcome sudden events or losses (such as major illness, economic loss or death) and try to recapture their earlier ideas about themselves. Finding an alternative identity, more adapted to circumstances, can take a long time.

Yet changes are inescapable for families: children are born and their development is punctuated by change (going to school, taking part in sports, making friends etc), which impacts on their parents and siblings. Levels of activity, intimacy, support needs, interactions outside the family, alter in keeping with the maturation of family members.

In clinical work, homeostasis is most evident when the family is encouraged to make changes to their usual transactional patterns. For example a family, where quarrelling had been the habitual way of dealing with feelings of loss and depression, started to quarrel again at the end of a session where these feelings had been openly discussed for the first time.

New to CAMHS p.97

Think systemically about the team/service you have recently joined. How does it find homeostasis? What is the emotional climate of the group? When something happens (such as the introduction of a new member of staff) how does it seek to re-establish equilibrium? Write your observations in your notebook and then compare with the shadow learner comments below. Then bring it up with your learning mentor or a trusted colleague.

I joined a new team some years ago which had had the same core members for many years, established in a comfortable team base. Subsequently I discovered many tensions beneath the surface. The way they maintained equilibrium was to always take their lunch together, preparing it in the kitchenette and sitting in the cramped common room, swapping notes on recipes, family gossip and shows or films recently seen. When a new member joined it would be made very clear that lunching together was expected. Food brought in by a team member on meeting days was also a way of maintaining the emotional climate of the group as a nurturing, closed system. Visitors had to wait outside the team meeting until invited in. The home made cakes would be on the table, but not explicitly offered to the visitor and thus the team stayed within its own boundaries, remaining comfortable whilst the visitor felt a sense of alienation.

The observations of the shadow learner lead us into the next perspective – that of the psychodynamic school. The shadow learner discovered hidden tensions or undercurrents in the team and felt the team defended itself from outside scrutiny by subtly making visitors or newcomers less welcome, whilst members sought to nurture and comfort themselves.

A psychodynamic perspective seeks the meaning to these actions by asking, “What was the team’s anxiety that it was seeking to keep at bay with its defence mechanisms?”

Psychodynamic perspectives




The main advantage of thinking about children and young people in a psychodynamic way is that it offers an understanding of their inner world and subjective experience – something that none of the other models do to the same extent. Sometimes children and young people with emotional and behavioural difficulties particularly struggle to make sense of what is happening to them, not only in the outer circumstances of their lives but also in their own feelings and behaviour. When they turn to us for help, they expect us to help them succeed: a working knowledge of psychodynamic ideas can be of great practical value.

Psychodynamic ways of thinking are based on the ideas that all behaviour has meaning and that some aspects of our experience may be unconscious and therefore not easily available for thought. Central to psychodynamic thinking are firstly the idea of anxiety, and secondly the idea of defensive mechanisms that may develop to keep the anxiety at bay. Although useful, or even a necessary protection in adverse circumstances, defensive structures can also be rigid or maladaptive.

New to CAMHS p.104

In psychodynamic thinking containment refers to the role of a care giver (including a therapist) being able to be the container for emotions that the child needs help to deal with. The term was first used by Wilfred Bion. But overwhelming feelings in the child, projected to the adult, may not always be contained, for a number of reasons. The adult may feel increased anxiety, or might be too pre-occupied to respond. Parents with mental health problems for example have difficulty in containing their children’s fears by responding to them with love and reassurance, because they themselves are depressed or lonely or fearful.

Failed containment may be:

-  intermittent (and uncharacteristic of the relationship between mother and infant);
-  specific (that is, the parent may have difficulty containing certain anxieties and not others
-  pervasive (the care-giver may not be able to contain the infant’s anxieties).

In psychodynamic therapy, the work takes place in the context of a relationship. This means that establishing a therapeutic alliance is a key priority, and the nature of the relationship between the child or young person and the therapist is the focus of attention. Children and young people are likely to behave towards a therapist or other members of staff in the way that they have been used to behaving with adults close to them. In this way (rather than by telling you directly), they reveal a lot about their inner world, their ability to trust, and the kind of anxieties they have.

Transference is put to therapeutic use when the therapist helps the child make sense of the way he relates.

Counter-transference (the mirror image of transference), is the name given to the feelings the therapist experiences in response to a child or young person's projection (for instance, irritation, or a wish to look after the child). These feelings can help understand how the child is feeling at that particular time, his unspoken needs.

New to CAMHS p.106

Cognitive and behavioural perspectives

Cognitive behavioural approaches to mental health problems and their treatment are underpinned by social learning theory - what we know regarding the way people learn about social behaviour. Social-learning theory is concerned with social interaction and builds on the fact that people, like animals, learn to use patterns of behaviour that are rewarded by their environment. Those behaviours that produce negative results are abandoned in favour of those that are reinforced by success.

Social-learning theory also takes into account internal cognitive processes: people learn from their behaviour because they can think about what they do, foresee consequences and change their behaviour accordingly.

Thinking and behaviour are also linked to feelings: these processes mutually influence each other.

Cognitive and behavioural forms of therapy use techniques based on learning to bring about change. It is assumed that prior learning, perhaps combined with new circumstances, is causing distress and maladaptive behaviour. Therapy offers ways of undoing this learning by helping people to explore their thinking and behaviour and detect those processes which are unhelpful to them. More adaptive learning experiences are planned so that new ways of thinking and behaving can be substituted.

New to CAMHS p. 107

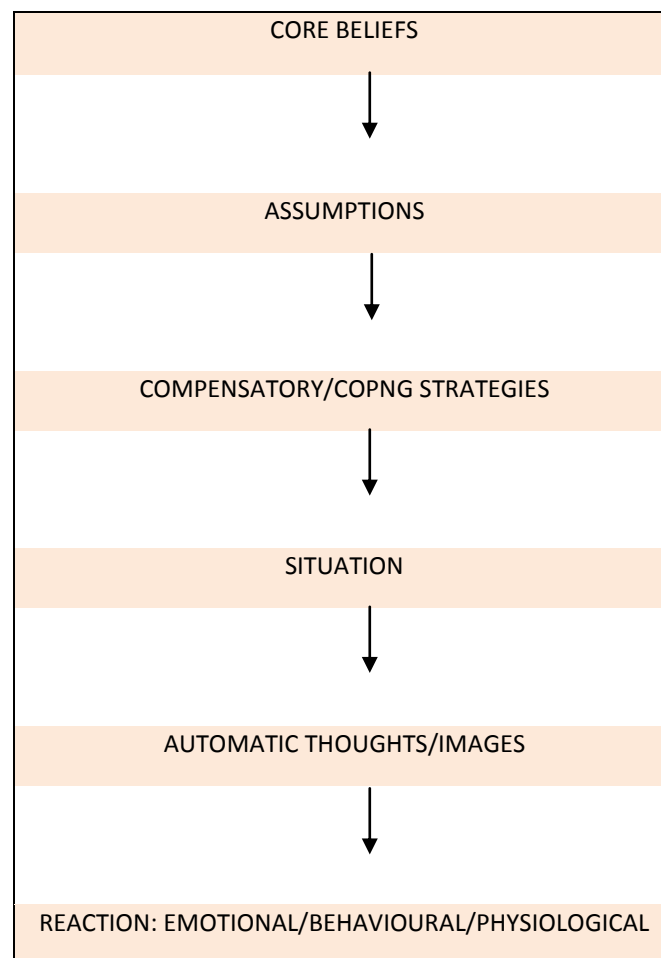
Many different therapies are based on a cognitive and behavioural approach, including individual or group based social skills training (anger management, self esteem, communication, etc.), parenting programmes such as Webster-Stratton and Triple P and cognitive behavioural therapy (CBT).

Cognitive Behavioural Therapy

CBT focuses on the power of thought and its relationship to behaviour. Thoughts are considered in respect of their meaning and implications, evaluated and analysed, then re-framed as balanced alternatives. The therapist does not seek to persuade the client that their thoughts are wrong or irrational, but instead to help them work out where they might be stuck and encourage them to find other ways of thinking about their situation. When more helpful/less threatening alternatives have been considered they are tested in real life.

An illustrative cognitive model is given below.

Cognitive model



A more detailed version, with examples of typical thoughts and behaviours is given below.

CORE BELIEFS
Helpless: I can't.....
Worthless: I am bad/dangerous.....
Unlovable: I will be rejected.....
ASSUMPTIONS
I won't be able to.... Bad things will happen.....
It will be too difficult..... I will get hurt.....
COMPENSATORY/COPING STRATEGIES
I won't try..... It's safer not to.....
I won't give anything then I can't be hurt...
They think I am bad so I will be.....
SITUATION
Parents divorce..... Exams coming up.....
New friendship..... School prom.....
AUTOMATIC THOUGHTS/IMAGES
Catastrophising: It will be a disaster, I will never recover
All or nothing: If I can't get an A I won't even turn up
Emotional reasoning: I feel strongly it won't work so it won't
REACTION: EMOTIONAL/BEHAVIOURAL/PHYSIOLOGICAL
It's my fault..... Fear..... Anxiety..... Sweat..... Palpitations..... Run away..... Avoid.....

Biological perspectives

The important aspect of a biological perspective is that it is the interaction between biological and environmental factors which is of primary concern.

The environment is a mediator of genetic vulnerability and the old debate about “nature versus nurture” is now widely considered to be redundant. It is the interplay between nature and nurture that is important.

Biological factors include:

- Genetic vulnerability to mental health problems, e.g. genes have been linked to a number of disorders including schizophrenia, bipolar disorder and ADHD. A number of genetic disorders are associated with certain behavioural and psychiatric difficulties, e.g. Fragile X.
- Macro- and microscopic brain abnormalities, e.g. the structural changes found in schizophrenia allowed the understanding that it is a neuro-developmental rather than a degenerative disorder.

- Neurotransmitter abnormalities associated with affecting mood and thinking have been identified for several mental health problems, for instance depression, schizophrenia, addictions, ADHD. These factors inter-relate so that a genetic vulnerability, when combined with environmental stressors, can result in changes to the structure and physiology of the brain and the development of symptoms. Alternatively, changes to structure/function can be environmentally acquired, e.g. a child who suffers a brain injury who then develops persistent behavioural changes.






New to CAMHS p.114

A holistic approach

A multidisciplinary assessment and formulation is required for the following young person:

Stefan is aged 12 and has been referred by the special needs school he attends because the classroom staff can no longer manage his disruptive behaviour and are worried about his mood swings. He is cared for by his grandparents whose understanding of English is limited. Stefan often arrives to school late and says he is hungry. He cannot concentrate for very long and becomes frustrated and angry, recently beginning to lash out at other children.

What sorts of information will be sought by each of the following practitioners:

-  Family therapist (systemic perspective)
-  CAMHS social worker (social perspective)
-  Clinical psychologist (psycho-social perspective)
-  Psychiatrist (biological perspective)
-  Mental health nurse (cognitive-behavioural perspective)¹

Check your understanding so far by going to Self Test on page 159. The suggested answers can be found in the Solutions section.

¹ **PLEASE NOTE:** WE HAVE ALLOCATED THESE PERSPECTIVES TO THE PRACTITIONERS FOR CONVENIENCE, RECOGNISING THAT INDIVIDUALS MAY USE A NUMBER OF DIFFERENT MODELS. WE ARE NOT SEEKING TO STEREOTYPE!

Using evidence

“Never theorize before you have data. Invariably you end up twisting facts to suit theories, instead of theories to suit facts”





Sherlock Holmes

Practice informed by evidence





Not so long ago, many services, including CAMHS, dealt with what came through the door, to the best of their ability, using their professional training to guide them. They kept cases on their books for quite some time as a precaution and sometimes did annual follow ups.

Why did it need to change?





We learned that demand is not the same as need – that what comes through the door depends on people:

-  Recognising that they might need a service
-  Knowing the service is there
-  Getting to the right gatekeeper to give them access to the service
-  Understanding what the service offers – and wanting what is on offer

We realised that professional trainings and theoretical backgrounds vary and their usefulness and applicability depends on:

-  Individual client needs
-  Type of presentation or problem
-  Level of complexity
-  What the client wants and feels comfortable with

We were confronted with problems, including:

-  Those most vulnerable not receiving a service
-  Large backlogs caused by open caseloads, creating long waits
-  Huge variability across the country, otherwise known as a postcode lottery
-  Little idea of what worked, with whom, or why

Evidence of what?

The first piece of the evidence jigsaw is evidence of need. A population needs assessment should be available – normally from the primary care trust (PCT), the local authority, or sometimes from the public health department. Your local CAMHS strategy should be based upon a population needs assessment.

The demography of the area needs to be captured and described, including an analysis of levels of deprivation and of vulnerable groups. However services can rarely meet all potential need, so we also need a clear picture of demand. This can be assessed by monitoring referrals to and requests for the service.

Having a clear picture of need and demand, the next step is to determine the appropriate types and levels of skill to deliver assessments and interventions that will be clinically effective. The skill mix of the team and the levels of competence, as well as ways of working for the best outcomes should usually be contained within the workforce plan.


The delivery of clinically effective interventions also needs to be cost effective and provide value for money. Evidence of the most efficient and cost effective ways to run the service can be produced by analysing processes such as time management, case load and case management. There are national tools available to help with caseload management (see section 3c), but practitioners can also conduct local audits or evaluations and will be required to supply activity data to managers as part of routine reporting.

Much of what we call evidence based or evidence informed practice relates to the evidence base for outcomes. Essentially we need to know that the results of interventions will produce benefits for children, young people and families. In assessing benefits it is also necessary to assess risk. Clinical outcomes refer to improvements of symptoms and alleviation of mental health difficulties; the evidence is available from NICE guidelines and systematic reviews of research findings. But it is also necessary to consider functional outcomes, such as whether family relationships become easier, or the child's attendance/performance at school improves, and so on. The assessment of functional outcomes should start by involving the service user in goal setting and care planning and engaging them in measuring progress towards agreed aims.


A summary of how the different types of evidence fit together has been shown on a slideshow available on the CD 'Evidence Jigsaw, then come back to this workbook.

Evidence informed by practice

In specialist CAMHS, as in many other areas of children's work, it is not always possible to inform our practice from the evidence. This is because the evidence base is still developing and there are gaps. Moreover the really robust evidence tends to be focused specifically on single disorders, whereas children and young people often have very complex presentations, characterised by:

 Multiple problems

and/or

 No single definable disorder

So, for example, there are national guidelines about the most effective interventions for children and young people with obsessive-compulsive, conduct and attention deficit hyperactivity disorders, among others. But pooling all this evidence (a feat in itself) for a young person presenting with a possible combination of all of those disorders does not really help, if your assessment has indicated that the underlying causes of the complex set of problems are childhood trauma, separation and loss. Children and young people we know to be more vulnerable to mental health difficulties, which can endure into adulthood, include those looked after and in care, those in the youth justice system, refugees and asylum seekers and those with a learning disability. For these children and young people, who have often had chaotic and disrupted family and school life, we have to be more creative.





Informing evidence from practice involves using multiple professional judgements when assessing and involving the child or young person in the assessment and intervention. Considering the child or young person's life and life chances holistically requires inter-agency working and long term planning and continuity. If the specialist CAMHS practitioner is the lead professional working with that young person, it requires that professional to be imaginative and eclectic, trying interventions that look from the evidence to be promising, but engaging in regular review to measure the effectiveness of those interventions.

For children and young people with complex needs the most effective interventions are very likely to be a combination of approaches and techniques. How these interventions work should be the subject of local audit, evaluation and reported case studies, the findings of which are shared among the professional networks.




The key to improving effectiveness is in measuring outcomes. There are recommended national measures that have been tested and validated so that practitioners, in partnership with children, young people and their parents or carers, can assess the results of interventions.

Finding and using evidence

The CAMHS Evidence Based Practice Unit (EBPU) has published a helpful booklet called “Knowing Where to Look”, the weblink can be found in the References section at the end. In finding the evidence you need EBPU suggests the use of a stepped approach, PICO:






-  P person or problem
-  I issues being considered
-  C comparison
-  O outcome of interest

Using PICO, identify a person or problem you have recently encountered and list the issues being considered. Think about where you would look for evidence of interventions you could use and how you would compare and select, based on the outcomes you would be aiming for. There is a worked example below. Discuss with your learning mentor or supervisor.

 Person or problem. Child about to enter secondary school, with severe challenging behaviour, assessed as conduct disorder.	
 Issues. What helps children with conduct disorder	Conduct Disorders - only for children aged 12 or under, or with a developmental age of 12 or under, NICE recommends group-based parent-training/education programmes in the management of children with conduct disorders. Individual-based programmes are only recommended where the family's needs are too complex for a group-based programme. TA102, find at: http://guidance.nice.org.uk/index.jsp?action=download&o=33427
 Comparison. How to select the most suitable approach	Conduct disorders are currently managed through a combination of interventions targeted at both the child and the family. Child-focused therapies include behavioural therapy, cognitive therapy, psychotherapy, social skills training, play therapy, music/art therapy and occupational therapy. To decide which approach would be most suitable go to the systematic review, <i>Drawing on the Evidence</i> at http://www.annafreud.org/dote_booklet_2006.pdf Discuss options with the family, child and school.
Outcome of interest. Prevent further escalation of child's problems. Improve behaviour in school and at home. Support parents and teachers.	

Measuring outcomes

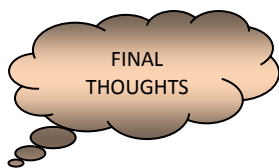
The CAMHS Outcomes Research Consortium (CORC) recommends the use of the following measures:

-  Strengths and Difficulties Questionnaire (SDQ) for the parent and child perspective
-  Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ) for the parent and child feedback on the service
-  Children's Global Assessment Scale (CGAS) for practitioner perspective
-  Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) for the practitioner's perspective
-  Goals Based Outcomes Measure (GBO) for joint perspective between practitioner, child and parent.

Your service may be a member of CORC, in which case you will be required to provide routine outcome measures to be submitted to CORC each year, enabling the service to share learning with others across the country and to receive an annual report showing how it compares with other services in England.

If your team or service is not a CORC member it is likely you will be using all or some of the above measures.

Just like the rest of the CAMHS evidence base, outcomes measurement is developing. Involvement with CORC and other local or national networks will enable you to share learning, avoid common pitfalls and understand better the consequences of your practice, so you can assure the users of your service of targeted, effective support that will help them to be mentally and emotionally healthy.



The ability to keep “a thinking space going” – especially when the day-to-day work with a young person is slow, sometimes unrewarding, or their problems severe – is essential for good treatment outcome, and for improving individual professional performance.

Evidence-based practice represents the ‘gold standard’ for NHS service delivery, but like many other NHS activities, much CAMHS work has a limited (if increasing) evidence base. So rather than uncritical acceptance of theory, a questioning approach, based on curiosity and the acceptance of uncertainty is important.

New to CAMHS p.6

Mental health problems and disorders, assessment and intervention

*“If we can really understand the problem, the answer will come out of it,
because the answer is not separate from the problem”*

Jiddu Krishnamurti
Indian Philosopher
(1895-1986)

This section of the induction is an overview of mental health problems and disorders, assessment and interventions. It cannot possibly cover the range of information necessary for a specialist practitioner and we have assumed many of you will already have covered these areas in your professional training. If you have joined specialist CAMHS without training in these areas, we hope this section will help you identify the gaps in your knowledge and competence, to inform your continuing professional development, which is addressed in the final section of the pack.

Child and adolescent mental health problems and disorders

Children and young people present at specialist CAMHS with a variety of possible problems and disorders. Very often they have more than one definable difficulty. Sometimes it is difficult to give the child or young person's difficulty a name, as it may fit more than one description or diagnostic category. Added to this, some practitioners are reluctant to give children and young people a label, because of the stigma attaching to mental health. So assessing mental health problems in children and young people is not straightforward and can be contentious.

The main mental health problems and disorders of childhood and adolescence are given on the next page. They relate to the diagnostic categories used in the two widely used manuals, DSM-IV and ICD-10 (full references are given for these manuals at the end.)

If you would like further information on any of the disorders listed below the Royal College of Psychiatrists website is also useful (see references).

Mental health problems and disorders in childhood and adolescence

Anxiety, worry, fears and phobias	
<p>Many things worry and frighten children, but these change with age. Symptoms are more likely to be expressed in unfamiliar circumstances and when the child is tired or ill. Young children commonly express isolated fears – like fear of animals, monsters or the dark. Some fears may be difficult to uncover.</p>	
<p>Assessment questions:</p> <p>Would you expect any child of a similar age to be anxious in the same circumstances?</p> <p>To what extent is the anxiety causing the child distress or interfering with his/her everyday functioning?</p> <p>Is the child showing other symptoms – like depression, weight loss or gain, conduct problems?</p> <p>Are parents or others unknowingly reinforcing the fear or anxiety by being overly concerned, giving too much reassurance, or giving in to it?</p>	<p>Treatment:</p> <p>When anxiety symptoms are age and situation appropriate, reassuring parents/carers may be all that is necessary, but they may need help in managing their own anxiety before they can manage their children's. Parents/carers should be warned that the child's anxiety may worsen when it is confronted, but as the child becomes better able to tolerate the object of fear, the anxiety will lessen. Generally, the child is exposed to the feared situation gradually, with pictures, role play, or at a safe distance, with the parent and child negotiating each stage; sometimes this can be done all at once, depending on the fear. Very occasionally low doses of medication are prescribed.</p>
<p>Separation Anxiety Disorder refers to excessive anxiety concerning separation from home or from a major attachment figure, with the level of anxiety beyond that expected for the child's age, lasting at least 4 weeks, and accompanied by 3 or more of 8 separation-related symptoms:</p> <ol style="list-style-type: none"> 1) 1 recurrent excessive distress upon or anticipating separation; 2) worry about losing or harm befalling major attachment figures; 3) worry that an untoward event will lead to separation; 4) reluctance or refusal to go to school or elsewhere because of fear of separation; 5) fearful or reluctant to be alone without major attachment figures at home; 6) reluctance/ refusal to go to sleep without being near major attachment figure or to sleep away from home; 7) repeated nightmares involving theme of separation; 8) repeated complaints of physical symptoms (headaches, stomach aches, nausea or vomiting) when separation from major attachment figure occurs or is anticipated. <p>These symptoms must cause significant distress and/or impairment in social functioning.</p>	<p>Generalised Anxiety Disorder (Overanxious Disorder of Childhood) is characterised by excessive and persistent worry, which the child finds hard to control and is not focussed on any one object or situation. This worry must be experienced more days than not over a period of at least 6 months, cause significant distress or impairment in functioning, and be accompanied by one of the following symptoms in children:</p> <ol style="list-style-type: none"> 1) restlessness or feeling keyed up or on edge; 2) being easily fatigued; 3) difficulty concentrating or mind going blank; 4) irritability; 5) muscle tension; 6) sleep disturbance – difficulty falling or staying asleep or restless unsatisfying sleep.

<p>Specific (or Simple) Phobias describe marked and persistent fear of circumscribed objects or situations – lasting at least 6 months. Such fears are usually transitory, and a diagnosis is not usually made unless there is excessive distress or impairment in social functioning.</p>	<p>Social Anxiety Disorder is a marked and persistent fear of social or performance situations in which embarrassment may occur. Exposure to the situation almost always provokes an immediate anxiety response, and the fear and excessive distress concerning the social/performance situation must persist for at least six months and be associated with significant avoidance or impairment.</p>
---	--

Post-traumatic Stress Disorder (PTSD)

PTSD is linked with an extreme traumatic stress or involving direct personal experience of an event that involves actual or threatened death or serious injury to self or someone close. The event is re-experienced in one or more of the following ways: flashbacks to the event, nightmares related to the event, re-enactment through play, intense emotional arousal, numbness around memories or reminders of the trauma, and physical symptoms such as tummy aches and headaches.

In addition, there are at least 2 of the following symptoms of avoidance: 1) persistent avoidance of thoughts, feelings or conversations associated with the trauma; 2) avoidance of activities, places or people associated with the trauma; 3) inability to recall an important aspect of the trauma; 4) diminished interest or participation in significant activities; 5) feeling detached or estranged from others; 6) limited or restricted expression of feelings; 7) limited sense of future.

Finally, there are at least 2 symptoms of increased arousal: 1) difficulty falling or staying asleep; 2) irritability or outbursts of anger; 3) difficulty concentrating; 4) hyper-vigilance; 5) exaggerated startle response.

Assessment:

It is sufficient to obtain a brief history of the trauma in order to understand the type of emotional upset being expressed. It is important to know whether there are legal proceedings pending and to establish whether it is an adult rather than the child who wishes to establish the severity of the symptoms. Go through the list of PTSD symptoms, noting symptoms associated with re-experiencing the event, then any non-specific changes in behaviour, increased arousal, and/or any new fears.

Treatment:

Parents/carers can help children deal with their memories and emotions by talking about the trauma. Thoughts and feelings tend to recur unchanged until they can be understood and tolerated. Following the child's cue for discussion is the best strategy, pressuring a person right after a trauma has occurred can make things worse.

Obsessive Compulsive Disorder (OCD)	
<p>Children are comforted by a predictable sequence of events. OCD must be distinguished from normal childhood rituals and concerns persistent obsessions, compulsions or both. Compulsions are repetitive behaviours aimed at preventing or reducing distress or preventing a dreaded event or outcome. However, the behaviours are not realistically connected with what they are designed to prevent or neutralise, though children are less likely than older adolescents that their obsessions and compulsions are products of their own minds or are excessive.</p>	
<p>Assessment:</p> <p>Parents/carers may be unaware of the extent of a child's compulsive behaviours, so questioning the child about the nature of the thoughts and behaviours is important. Asking him/her to keep a diary can be very useful. As with other worrying conditions, knowing the child's family circumstances is important, since, for example, the child's symptomatic behaviour may be designed to bring quarrelling parents together.</p>	<p>Treatment:</p> <p>If OCD symptoms are time consuming, distressing and interfere with the child's normal routine, then she/he should be referred for specialist treatment as soon as possible. Cognitive-behavioural therapy with family therapy is most effective. Medication may be prescribed, but not in isolation.</p>

Attention-Deficit Hyperactivity Disorder (ADHD)	
<p>ADHD is characterised by pervasive lack of attention, impulsivity and hyperactivity across situations and settings – at home, school, and in public – which began before age 7, persisted for at least 6 months and is associated with behaviour that is maladaptive and inconsistent with developmental level.</p>	
<p>Assessment:</p> <p>There is debate about whether ADHD is a discrete diagnosis and whether the interests of parents and teachers rather than the interests of children are being served in diagnosing and prescribing medication to treat it. If sufficient numbers of symptoms are present, and impaired functioning is directly related to the symptoms, the diagnosis is made. Associated features often include: defiance, aggression, dis-inhibition with adults, conduct problems, low IQ, dyslexia, clumsiness & history of developmental disorders.</p>	<p>Treatment:</p> <p>ADHD uncomplicated by behaviour problems can be seen in children up to the age of 7, and early intervention can prevent the development of commonly associated problems. Multifaceted interventions are recommended, including work with the school and parents. Where there is significant impairment, medication can improve attention and reduce physical restlessness, it does not improve behaviour.</p>

Conduct/Anti-social Disorder	
<p>This disorder is characterised by persistent failure to control behaviour and breaking of age-appropriate socially-defined rules, defiance and anti-social behaviour that persists for 6 months or more and impairs every-day functioning. Symptoms include aggression to people and animals. Onset of Conduct Disorder before age 10 is more commonly associated with aggressive and destructive behaviour, with typical onset in early teens and before age 16.</p>	
<p>Assessment:</p> <p>Complaints about children's behaviour problems are among the most frequent to CAMHS professionals. The first consideration is whether such behaviour is 'age appropriate'. Up to the age of 5, children are likely to be active and boisterous, test limits, experience difficulties in occupying themselves and demand more adult attention than parents/carers are prepared to give. Such behaviour may persist after age 5, but tends to subside with age.</p>	<p>Treatment:</p> <p>Once a distinction is made between normal naughtiness and behaviours that cause distress or impairment, professional intervention can be helpful. However, treatment is likely to be most effective before a child is eight years old, since anti-social habits will be less ingrained, and he or she is unlikely to be part of a deviant peer group. Whatever the underlying causes, multi-agency co-operation is especially important in dealing with conduct problems, since health, education and social work can make valuable contributions to helping these children and their families.</p>

Major Depression	
<p>Sad mood, tearfulness, loss of interest, and social withdrawal are common among children with unhappy life experiences but may not be part of a syndrome of either major depression or dysthymia - a persistently low mood that lasts for a year or more. These rarely occur before age 6 years and are uncommon before adolescence when rates increase markedly. Major Depression refers to one or more periods of depressed mood or loss of interest or pleasure, lasting at least two weeks and accompanied by at least four symptoms including: change in appetite or weight loss or gain, disturbed sleep, physical agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, difficulty concentrating or indecisiveness, and recurrent thoughts of death or suicide.</p>	
<p>Assessment:</p> <p>Interviewing the young person alone as well as with a parent/carer is recommended, since parents may be unaware of how their child is feeling. Open questions about mood, participation and enjoyment of usual activities, relationships with friends and family and feelings of self-worth are generally asked first and then additional questions about associated symptoms, such as change in sleeping, eating, and suicidal ideas or intent, as well as recent life events, stressors and losses.</p>	<p>Treatment:</p> <p>A useful starting point is explaining to the parents/carers— with the consent of and in the presence of the young person – how the child is feeling. Treatment should be tailored to the young person and family and may include social and psychological interventions and medication.</p>

Mania (Bipolar Disorder)	
Bipolar disorder or a manic episode is defined by a distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least a week and accompanied by symptoms of inflated self-esteem or grandiosity, decreased need for sleep, more talkative or pressure to keep talking, flight of ideas or racing thoughts, distractibility, increased activity or agitation, excessive involvement in pleasurable activities with high potential for painful consequences.	
Assessment: Depending on the presentation, issues of self-harm and child protection may require an urgent assessment of risk.	Treatment: With social supports, the acute phase of a manic episode can be managed at home. However, if the mania is moderate or severe, inpatient care is likely to be most appropriate. Medication typically is used both acutely and once the mood has stabilised.

Disorders of Attachment	
Attachment disorders are those that describe children who are excessively inhibited or excessively dis-inhibited in their social interactions – as a result of known parental separation, abuse and/or neglect.	
Assessment: Disorders of attachment are primarily seen in children who come from highly dysfunctional families and have histories of parental abuse and neglect. Many will have been taken into care, and some have had multiple placements in foster care or children's homes. Such children find it difficult to trust – or interact closely with – adults or children and are at risk of a range of mental health problems.	Treatment: Psychological treatment is unlikely to be successful in the absence of a stable care arrangement. Because of the difficulty in achieving such stability, some therapists have begun to provide support and advice to foster carers, staff of children's homes and other professionals to help them understand and cope with the complex needs and behaviours of such children.

Asperger's Syndrome	
Asperger's syndrome is a developmental disorder that is sometimes considered to be on the milder end of autistic spectrum disorder (ASD).	
Assessment: Asperger's Syndrome is characterised by impairment of social interaction and unusual interests and activities similar to autism.	Treatment: An educational statement can be helpful if desired by parents/carers who are aware of the child's difficulties and wish for more sensitive educational input, especially at secondary school level where the child's difficulties with empathy and subtlety of language are likely to lead to feelings of frustration and lower marks.

Autism	
<p>Autism has an early onset, often picked up by health visitors before age 3. Three types of impairment are always present:</p> <ol style="list-style-type: none"> 1) a lack of social reciprocity, with 50% not reciprocating at all, others display little or no response to commands and little or no empathy; 2) poor communication, with 50% with no useful speech, and others with echolalia, pronoun reversal, use of idiosyncratic phrases, invention of words, and/or use of stock phrases, and 3) restricted and repetitive activities, resistance to change, following set routines and/or stereotyped behaviours such as hand-clapping. 	
<p>Assessment:</p> <p>Autism is a pervasive developmental disorder and behavioural syndrome that arises from abnormalities in central nervous system development, probably in the foetus. There are serious impairments in social functioning and interaction (which may be poor to non-existent), in language and non-verbal communication, and in play, which tends to be unimaginative, repetitive, ritualistic or obsessional. Autism is often associated with moderate to severe learning difficulties, and sometimes with hyperactivity, severe temper tantrums, self injury and phobias.</p>	<p>Treatment:</p> <p>Psychological treatment programmes can help parents/carers in modifying children's behaviour, enabling them to cope with specific difficulties, and ensuring optimal schooling. Helpful advice to parents is that it is more effective to change the environment around the autistic child than to attempt to change the child.</p>

Psychoses	
<p>These are rare in children and adolescents, but may involve transient states or short episodes of delusions, hallucinations, disorganised speech, or grossly disorganised or catatonic behaviour. Such states are more likely to be associated with substance misuse.</p>	
<p>Assessment:</p> <p>Children commonly experience hearing voices. These questions and the answers help decide when the voices are cause for concern follow. Where is the voice? If outside the head, as if someone else is really talking. Whose voice is it? If a frightening or unknown being. How many voices are there? Several. Who are the voices talking to?</p>	<p>Treatment:</p> <p>Episodes of suspected psychosis should be referred to and treated by CAMHS.</p>

Eating disorders	
<p>Anorexia</p> <p>Anorexia is characterised by a refusal to maintain a minimally normal body weight, intense fear of gaining weight and significant disturbance in perception of own body shape or size. In anorexia starvation becomes an addiction.</p> <p><i>Treatment:</i></p> <p>Before referral or while waiting for a specialist appointment for anorexia, three steps might be taken.</p> <ol style="list-style-type: none"> 1) Help parents/carers face the potentially life-threatening nature of the problem and encourage them to come up with ways that might encourage the child to resume eating more normally. 2) Engage the young person in externalising the problem – something that can take people over and hurt them. 3) Encourage young person and parents to keep a food intake diary, setting a target for weight and weekly or fortnightly weighing to monitor progress. 	<p>Bulimia</p> <p>Bulimia is characterised by binge-eating and purging and maintaining adequate body weight is found more commonly among older adolescents.</p> <p>In bulimia binge eating is a habit that is hard to give up.</p> <p><i>Treatment:</i></p> <p>Bulimia sufferers are more successful at keeping their problem secret and reluctant to seek help, but if they do, cognitive-behavioural therapy or interpersonal therapy can be effective.</p>

Schizophrenia	
<p>Schizophrenia is a disturbance that lasts for at least 6 months and includes at least one month of active phase symptoms, i.e. two or more of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, or social, emotional or motivational withdrawal.</p>	
<p><i>Assessment:</i></p> <p>Young people with schizophrenia may be agitated or behave strangely if they are caught up in their psychotic delusions or hallucinations. There may be a marked reduction in social contacts, deterioration in general and academic functioning, and or a reduction in personal care and hygiene.</p>	<p><i>Treatment:</i></p> <p>Acute psychosis is likely to require inpatient care and medication. Longer-term management of psychosis may include strategies to reduce stress and distress associated with hallucinations, such as diversionary tactics, relaxation and recreational activities. Cognitive-behavioural therapy can help the young person develop skills and appropriate coping strategies.</p>

Suicidal Behaviour & Deliberate Self-Harm

These are both rare in children under 12 years. The decision to attempt suicide often is a hasty one - following arguments with family, friends and partners. Those who fail in their attempts often regret their actions, but all attempts should be taken seriously. Deliberate self-harm without suicidal intent takes many forms and can be seen as a way of dealing with difficult feelings that build up inside.

Assessment

Common Assessment Framework

Before a child or young person is referred to specialist CAMHS they should have been assessed by other professionals, using the Common Assessment Framework (CAF). The CAF is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. It is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met. It can be used by practitioners across children's services in England.

The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The CAF also aims to improve integrated working by promoting coordinated service provision.

CAMHS Assessment

The purpose of assessment in specialist CAMHS is to produce a full, detailed picture of all the factors, past and present, that have an impact upon the child or young person's strengths and difficulties, the resources they may have available to deal with their problems and the risk and resilience aspects of their lives.

The production of this detailed picture can lead to a formulation of the problem, and/or a diagnosis of one or more recognised mental health problems or disorders. Clarity in the formulation or diagnosis is important in determining which intervention is likely to produce the greatest benefits (outcomes).

During assessments you will gather information that spans several of the models we have discussed. This in turn will suggest several different types of interventions. A first assessment always includes developmental, systemic, bio-medical and psychosocial perspectives while full cognitive-behavioural or psychodynamic assessments are usually postponed till later. The process of assessment comes to an end when the most significant aspects of the child's problems have been clarified in a way that makes sense to the referrer, the child's carers and preferably the young person too. It should be in keeping with the scientific knowledge available in the literature. However, it is

important to keep an open mind regarding the possibility of having missed significant data, and questions are likely to remain which can be laid out clearly for further assessment. Possible treatment goals are identified at this stage, options can be discussed and decisions made regarding desirable — and realistic — interventions. Like the assessment, the formulation will include the perspective of the child/young person, and that of the family who will also be involved in drawing up the intervention plan.

New to CAMHS p. 64




Assessing a young person's mental health requires the professional completing the assessment to be familiar with several different models, each of which contribute a perspective to the understanding of mental health and the causes or antecedents of problems, disorders and illness. The assessment offers insight into the nature of mental health problems and their often complex causes. Many young people's problems can be understood in several different ways, each of which can offer reasons why problems come about and potential therapeutic solutions.

A holistic approach to assessments

Several members of the multi-disciplinary team, with different professional expertise, may need to collaborate to obtain a comprehensive assessment. A psychiatrist may be part of the multidisciplinary team conducting the assessment, but specifically will be involved when a diagnosis is required and where there may be other medical conditions.

There are three main challenges in maintaining a holistic approach in CAMHS work: theoretical, practical, and deciding 'who is the expert' — the professional, the child or young person, their family, or all three.

How is a CAMHS assessment conducted?

-  A CAMHS assessment may take up to four sessions, but this varies according to the situation.
-  For example a crisis intervention assessment may occur in one session over just an hour or two.
-  The assessment sessions for non-crisis assessments generally includes a session with the child or young person alone, a session with the parent/s or carer/s alone, and possibly a session involving the whole family.

During assessment many different topics are discussed and explored, including the child's current difficulties, their developmental history, family history, current family circumstances and relationships, and the parent/s or carer/s own families of origin. This information helps the practitioners reach a thorough understanding of the strengths and difficulties. With the family's permission, further information may also be sought from other professionals such as the GP, teachers, paediatricians and other children's services practitioners.

Additional specialised assessments may be recommended such as cognitive or learning assessments, psychometric testing, Speech and Language, or Occupational Therapy assessments.

Below is a brief synopsis of how a diagnosis is reached at CAMHS and the feedback that is given to young people and their families.

How are diagnoses reached at CAMHS?	What is Feedback?	
<p>One aspect of the CAMHS assessment process is determining whether a child or young person meets criteria for a particular psychiatric disorder.</p> <p>Disorders may be social, emotional, family-based, biological or behavioural in nature, or may reflect a combination of all of the above.</p> <p>Diagnosis is determined by exploring the child's difficulties as described, along with the other information discussed during assessment.</p>	<p>At the completion of the assessment, the CAMHS clinician will provide a feedback session to the parent/s or family. Families will make their own decision about which recommendations they wish to follow through with.</p> <p>If they are offered and accept CAMHS services, then a care plan is negotiated and agreed by the young person (where appropriate), the parent/s or carer/s and the clinician.</p>	
	<th data-bbox="596 1285 1417 1341">What interventions may occur after feedback?</th> <td data-bbox="596 1355 1417 1720"> <p>Treatments and therapies offered at CAMHS include individual therapy with the child alone, parent therapy with parents alone, or family therapy with the whole family. Groups for children and young people and for parents and carers may also be offered.</p> <p>CAMHS clinicians also provide consultation to other agencies to enable practitioners in other services to support emotional well being. Sometimes treatment may include recommending the use of a medication.</p> </td>	What interventions may occur after feedback?

For many years children and families had to wait a long time for a CAMHS assessment, sometimes up to two years. The situation has improved greatly, evidenced by the waiting times reported to the National CAMHS Mapping exercise since 2003. However some services still struggle to manage caseloads and waiting times for specialist assessments in particular can still be too long. Sometimes parents experience problems in convincing their primary care practitioner (GP, paediatrician, etc) of the need for a CAMHS referral. Once they finally get a referral, the time to assessment might be quite short, but their experience is of waiting many years. Professionals may not appreciate how difficult and stressful this wait can be for young people and their families and caregivers.

CAMHS REVIEW Key recommendation: It is important to improve the quality of CAMHS experienced by children, young people and families by reducing waiting times from referral to treatment. The Government should set clear expectations around good practice in this area, and specifically promote approaches that have worked well in reducing waiting times for other services (p.59).

Read the letter below from a parent about her 'excitement' at finally getting a CAMHS assessment for her daughter after 'a long wait'. She said that when she told the consultants she saw how long she had waited for an assessment they were really surprised; but she knew many other parents in the support group she attended who had waited even longer.

Hope this helps the professionals understand what it is like to be a parent of a child with difficulties who is not getting any help. Sorry it isn't typed, we don't have a computer.

Hi to all the professionals doing this course, I just wanted to share with you all my excitement at finally getting a CAMHS assessment for my daughter (will be 9 in 2 weeks).

Hearsh... at long last the ^{full} assessment began last week and at long last I have the full attention of a team of professionals who fully understand and want to hear everything I have to say in regard to my daughter's ongoing difficulties/complexities.

The first session was ^{about} 2 hours long, we compiled a family tree and they explained the assessment process step by step to me. Next month someone will do a detailed development history with me while someone takes my daughter to the other room to do some logical games/tests.

They are testing her for Aspergers / social communication anxiety disorder. I have been given some questionnaires to fill in and some to give to her school.

They explained at the end of the assessment we would be introduced to a family psychiatrist who would make the final decision of what will help my daughter. (I hope the school complete them so they don't like paperwork.)

I was asked why I was only now requesting a referral when we have been seeing so many different professionals to get help for my daughter. I told them I had been asking for help and raising concern since she was a toddler and asking for a referral since she started school.

They said - "You are in the right place now."

Think about what you have read. What do you think parents and carers would say about getting an assessment at your service? Do you know how long the waiting time is for an assessment? Make some notes in your notebook and think about checking it out with some service users.

Interventions

For many years specialist CAMHS interventions were guided by theoretical models but increasingly theoretical perspectives have been augmented by evidence of effectiveness. The evidence base for CAMHS interventions is, however, limited to certain problems and disorders and is still evolving. Many children and young people present with ambiguous or undefinable problems and a large number have multiple problems; the growing evidence base does not yet suggest the most effective interventions for such cases. Much of the choice of intervention is therefore guided by professional judgment and a knowledge of what is tried and tested: what we might call practice based evidence.

Try the matching exercise in the Self Test section, page 160 of this manual. The correct answers can be found in the Solutions section.

The matching exercise is based on a summary of evidence based interventions provided by Wolpert et al (2006). The correct matches are given on the following page. The table is also provided as a stand-alone item in the resources section, so you can use it again at a later date. Remember this is a very brief summary and if you are not familiar with the material, you need to read the full report in Wolpert et al's booklet, which is obtained by following the link in the References at the end.

EVIDENCE BASED INTERVENTIONS FOR SPECIFIC MENTAL HEALTH PROBLEMS AND DISORDERS

ANXIETY DISORDERS	Behaviour therapy Cognitive behavioural therapy (CBT) Interdisciplinary work Prescribing, medical intervention	EATING DISORDERS	Behaviour therapy Family therapy
COPING WITH CHRONIC ILLNESS AND DISEASE	Behaviour therapy Cognitive behavioural therapy (CBT) Psychoanalytic psychotherapy Specialist nurse support Systemic psychotherapy	PERVASIVE DEVELOPMENTAL DISORDERS	Behaviour therapy Prescribing, medical intervention
COPING WITH PAINFUL PROCEDURES	Behaviour therapy Child development knowledge Hypnosis	PHYSICAL SYMPTOMS NO KNOWN CAUSE	Cognitive behavioural therapy (CBT) Nutrition advice
DELIBERATE SELF HARM	Family work Group psychotherapy	POST TRAUMATIC STRESS DISORDER	PTSD knowledge/therapeutic skill Trauma focused CBT
DEPRESSIVE DISORDERS	Cognitive behavioural therapy (CBT) Family therapy Individual personal therapy (IPT) Prescribing, medical intervention	PSYCHOTIC DISORDERS	Prescribing, medical intervention
DISORDERS OF CONDUCT	Interdisciplinary work Multi systemic therapy (MST) Parenting interventions Prescribing, medical intervention Social work input	SUBSTANCE MISUSE	Family therapy Multi Systemic Therapy (MST)
DISTURBANCES OF ATTENTION	Behaviour therapy Interdisciplinary work Nutrition input Parenting interventions Prescribing, medical intervention	TOURETTES SYNDROME	Prescribing, medical intervention

Given the evidence base for CAMHS is still developing, there are nevertheless some interesting patterns in the material we have been considering in the matching exercise. Did you notice that certain interventions cropped up more frequently than others? What do you make of that?

Jot your ideas in your notebook and discuss with your learning mentor or a trusted colleague.

How do you decide on the most suitable intervention to use with a client? List the factors you take into consideration and how you assess whether the intervention has been effective. Then compare your responses with the shadow learner below.

I do try and be guided by the evidence base, including the NICE guidelines. BUT it only really helps when I have made a clear cut formulation from the assessment. More often than not the child and the whole family present with such complexity of issues that it is more a case of try this, if it doesn't work, try that. What I find valuable is discussing the progress of a child or young person with the team or my supervisor. Colleagues are great at suggesting alternative ways of working, or pointing me to clinical articles so I can tailor the intervention to the child's specific needs.

Recently my organisation has introduced a new care planning scheme which requires us to involve the child (and family) far more in deciding what the treatment goals are. This doesn't provide all the answers but it is helpful to all of us and keeps me grounded. Kids usually know what they want, how they want their lives to improve. You have to sometimes give them a reality check (eg I can't make your parents un-divorce) but generally what they suggest is do-able and gives us focus.

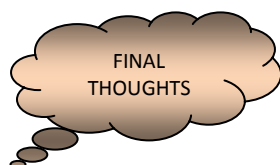
The shadow learner uses colleagues, supervision and involvement of the client, as well as trying to be guided by the evidence, pointing out that the evidence can be a bit overwhelming. Guidelines from the National Institute of Clinical Excellence (NICE) are detailed and require careful reading – we will address these in the next section.

After this brief tour of disorders, assessment and intervention, take the self test below. The test is a simple True/False. For speed, just write the numbers 1-7 in your notebook and put T or F as appropriate next to each.

	TRUE	FALSE
1. Most children and young people present to specialist CAMHS with a single diagnosable mental disorder.		
2. CAF stands for Carer's Assessment Framework		
3. A CAMHS assessment is normally carried out by a psychiatrist		
4. Behaviour therapies are recommended for several childhood mental health problems and disorders.		
5. Developmental disorders include autism and Aspergers.		
6. Decisions about intervention should be based solely on the evidence for effectiveness.		
7. Most families no longer have to wait a long time for a CAMHS assessment.		

Please see correct answers below

	TRUE	FALSE
1. Most children and young people present to specialist CAMHS with a single diagnosable mental disorder.		✗
2. CAF stands for Carer's Assessment Framework		✗
3. A CAMHS assessment is normally carried out by a psychiatrist		✗
4. Behaviour therapies are recommended for several childhood mental health problems and disorders.	✓	
5. Developmental disorders include autism and Aspergers.	✓	
6. Decisions about intervention should be based solely on the evidence for effectiveness.		✗
7. Most families no longer have to wait a long time for a CAMHS assessment.	✓	



This section has covered, extremely briefly, the core, major issues for a specialist CAMHS practitioner. We cannot do justice to these core elements within an induction course. Think about your own competence in recognising, assessing and treating the mental health problems and disorders of childhood and adolescence and, where you have identified gaps, consider your continuing training and developmental needs, to discuss with your supervisor.

Case Study – Kieran

6 – 12 years

Very early in Kieran's formal schooling, teachers were noting regular concern about his behaviour. His behaviour was noted to be 'anti-social' and often verbally and physically violent to teachers and other pupils. On a number of occasions, Kieran was removed from school for a few days.

The head teacher wrote a number of letters to Kieran's parents outlining the issues of his behaviour but his parents were elusive and rarely responded (see school letter). Occasionally his father would engage in a response to these issues; but when he did contact the school, it was normally to defend Kieran and claim it was other boys who caused Kieran to get in trouble. He claimed the school was discriminating against his son. The head teacher often noted that Tony seemed unable to address the issues surrounding Kieran's behaviour.










It was during this time that Kieran's mother was diagnosed with depression by her GP. She was prescribed medication and some counselling. The depression was a major concern for all concerned as often Sarah would state she was unable to care sufficiently for Kieran. Tony was noted to be 'distant' in the treatment programme for Sarah and concentrated his energies on caring for Maeve.

The GP referred Sarah to the counselling service attached to the practice. She was initially seen by an experienced counsellor who Sarah felt she could relate to. Unfortunately this counsellor left for a new job after three sessions with Sarah - despite being an experienced counsellor, well trained and well liked, she rarely kept good notes and these were often indecipherable (see counselling service case note). After she left, Sarah was offered an appointment with a locum counsellor, however she choose not to attend and the practice did not send another appointment.

Your notes and queries...




Issues/potential problems

What issues does the above raise for you in respect of:

-  Pre-natal influences on mental health
-  Parental mental health history
-  Parental mental health problems
-  Safeguarding
-  Managing risk and resilience
-  Early intervention
-  Mental and emotional health in schools
-  Effective interventions to help children with mental health problems – those who, in a school context, would broadly be described as having behavioural, social or emotional problems
-  Record keeping

Skills

If you were consulting to staff such as GP's, primary and junior school teachers, classroom assistants etc, what advice, as a specialist mental health professional, would you give in respect of:

-  What is the role of Sarah's depression on Kieran's development? What kind of holistic treatment package would need to be in place to help Sarah, Kieran and the rest of the family?
-  Tony and Sarah are reluctant to work together. How might they be engaged and motivated to agree a joint plan?
What is the role and what are the skills of a CAMHS worker in achieving this aim?
-  Sarah has become 'helpless' in her ability to manage Kieran – is this linked to her depression?
What could be done to help Sarah overcome this feeling of helplessness?

Write your ideas in your notebook and discuss with your learning mentor or a trusted colleague.



WILLINGTON SCHOOL, LOWER SCHOOL LANE, SCHOOLINGFORD, SC1 0HL
TEL: 0118 529 8741 FAX: 0154 569 825
HEADTEACHER: MR S COLLINGSWORTH

*Mr and Mrs O'Reilly
1 The House
Road Avenue
Homesford, H6 7SE*

Dear Mr and Mrs O' Reilly,

Re: Kieran O'Reilly

I am writing to you about a number of incidents concerning your son Kieran.

His form teacher has informed me about an episode involving swearing during class. As you know we have a policy of respect for each other in this school and the use of bad is not tolerated. His teacher stated that during this recent incident she also felt threatened by Kieran's aggressive behaviour.

Later that day, Kieran ran out of his English class into the playground and tried to climb over the school gate into the street. When a member of staff tried to stop him, he kicked out at her and spat at her; we eventually managed to control his behaviour and get him safely into the school building.



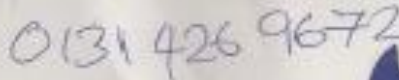
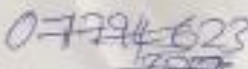

Additionally it is noted that Kieran has been fighting with another boy on the school premises in the mornings before school, and these fights are becoming very violent.

Kieran has now been excluded from school on two previous occasions and as you are aware the next step is permanent exclusion from the school.

Please contact me with a date and time when we can meet to discuss this situation.

Yours sincerely

Mrs S Reagan
Deputy Head








Please ensure this record is hole punched and put in the correct client file

Case note

This is a private and confidential record sheet for recording client meetings. Remember to complete all details in the information box.

COUNSELLING SERVICES

Client name	Sarah Chatterley O'Reilly
Client case reference	SO-1934
Date	31st March 2005
Counsellor name	 W.M.K.

See previous notes: (ref. SO-1934)


~~She~~ appears to be very depressed & I have concerns about the bond between her & her husband. Sarah shows no experience of shared responsibility for the children and feels it is all down to her. (Kieran & Robbie)

She has a real sense of ~~blame~~ blame for the difficulties she has with Kieran. She could not describe the intimacy between herself and her husband - very isolated in the relationship. No evidence of external relationships/networks. Kieran's info + leaflets handed. Need to work with both Sarah and Kieran on relationship - together and children.

→ just counselling suggested - but Sarah feels husband will not agree - ~~explore~~

Case referred? → Back to GP? → 07

Mr Dennis,
 46 The Rectory
 Surgery Street
 Radford



References

CAMHS Outcomes Research Consortium (CORC)

<http://www.corc.uk.net/>

Common Assessment Framework

<http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/caf/cafframework/>

Department of Children Schools and Families (2008) *Children in Mind. Final Report of the CAMHS Review*

<http://www.dcsf.gov.uk/CAMHSreview/>

Diagnostic and Statistical Manual OF Mental Disorders (DSM-IV)

<http://allpsych.com/disorders/dsm.html>

International Classification of Diseases (ICD-10)

<http://www.who.int/classifications/icd/en/>

National Service Framework for Children, Young People and Maternity Services

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089101

NHS Health Advisory Service (1995) *Review of Child and Adolescent Mental Health Services: Together We Stand*. London: The Stationery Office

Royal College of Psychiatrists

www.rcpsych.ac.uk/mentalhealthinfo.aspx

Royal College of Psychiatrists

www.rcpsych.ac.uk/mentalhealthinfo.aspx

Shribman, S., & Billingham, K., (2008) *The Child Health Promotion Programme* (updated). Department of Health
Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Phillips, J., Pilling, S., Stein, S., & Target, M. (2006) *Drawing on the Evidence Advice for mental health professionals working with children and adolescent*. 2nd Edition

http://www.acamh.org.uk/site/upload/document/Drawing_on_the_Evidence_-_text.pdf

The Quick Guide to NICE Guidance and CAMHS

<http://www.newwaysofworking.org.uk/content/view/25/436/>

Wolpert, M., Fuggle, P., Cottrell, D., Fonagy, P., Phillips, J., Pilling, S., Stein, S., & Target, M. (2006). *Drawing on the Evidence. Advice for mental health professionals working with children and adolescents*.

<http://www.ucl.ac.uk/clinical-health-psychology/pdfFiles/DotEBooklet2006.pdf>

World Health Organisation

<http://www.who.int/features/qa/62/en/index.html>

The structure of specialist CAMHS

“A structure becomes architectural, and not sculptural, when its elements no longer have their justification in nature.”

Guillaume Apollinaire





French author

1880-1918

History and evolution

Use of the term Child and Adolescent Mental Health Services (CAMHS) seems to have started after 1975 with the first government recognition that mental health services for children and young people should be based in the community rather than in institutions. Prior to that child guidance clinics had been based largely in local authorities and children with more serious problems were placed in health service hospital units. Throughout the 1990s many CAMH services were provided by NHS organisations whose main business was adult mental health.

In 1995 the NHS Health Advisory Service published *Together We Stand*, a document that became the cornerstone for the strategic planning, delivery and evaluation of CAMHS for many years and is in fact still cited widely today. The legacy of *Together We Stand* is still evident in much recent policy, but its most memorable achievements were:

-  The introduction of national standards
-  The emphasis on inter-agency working
-  The strategic framework of four tiers
-  The idea of primary care workers

The Audit Commission in 1999 published *Children in Mind*, a review of mental health provision for children and young people that made a number of recommendations for change and reinforced the nomenclature of CAMHS. In the four years since *Together We Stand* the Commission did not record much progress in the systematising of CAMHS and being clear about its functions.

During the 1990s developments around the country included the drafting of local CAMHS strategies and the formation of Boards or joint working groups that became known as CAMHS (Strategic) Partnerships.

In 2004 the National Service Framework for Children, Young People and Maternity Services was published by the Department of Health, setting out a ten year plan. Prior to that and in anticipation of it, the National CAMHS Support Service (NCSS) had been established in 2003, placing a CAMHS development worker in each region to support a more strategic approach to developing services.

2004 also saw the publication of Every Child Matters by the then Department for Education and Skills (DfES). These two major policies became the twin drivers for reform and from them came the introduction of targets, described in the Public Service Agreement (PSA), which is essentially the way the public sector demonstrates to the Treasury: value for investment of public funds and fidelity to national policy.

Progress on reform in CAMHS was assessed and described in a report from the Department of Children, Schools and Families (DCSF) in 2008, entitled With Children in Mind, The CAMHS Review. In 2009 the government published its official response to the CAMHS Review.

The above represents a summary of the most influential policy on the developments in CAMHS. This is by no means an exhaustive list and there have been many more policies, guides and initiatives which have helped to shape specialist CAMHS within wider children's services today.

Frameworks for the strategic planning of CAMHS

Together We Stand introduced the four tiered framework to conceptualise CAMHS as a multi-levelled set of inter-related services, each level appropriate to meet the different needs of children and young people. The model was widely adopted until recently, when the greater integration with other services for children seemed to demand a rethink. The CAMHS Review (2008) had this to say about it:

The four-tiered model has been used for over a decade to conceptualise the planning and delivery of mental health services. We recognise that this model is well embedded within the culture and the systems of health services. Across children's services more widely, there has been a more recent move to the concept of universal, targeted and specialist services. Both models are subject to local interpretation and differences in understanding, although they share the basic aim of helping people understand which services are available to everyone and which are available to some.

The CAMHS Review explanation of each tier is given below.

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

The CAMHS Review description of the ECM framework:

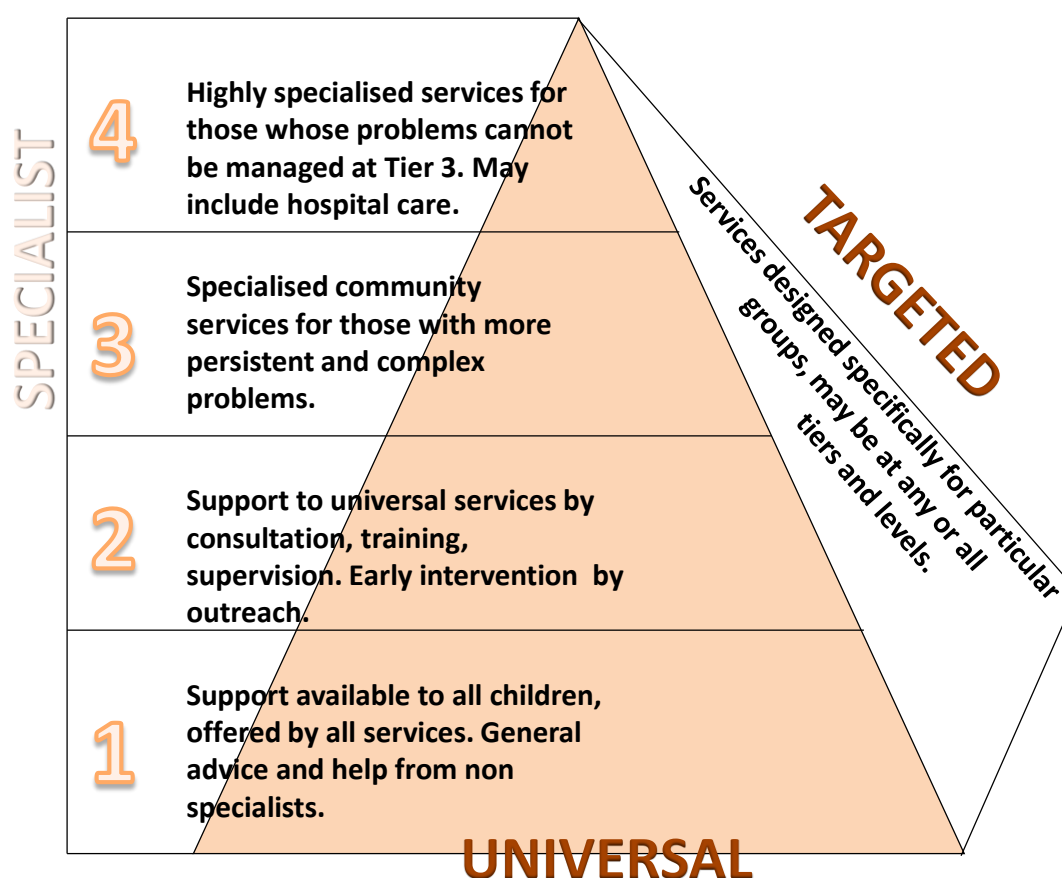
Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include early years providers and settings such as childminders and nurseries, schools, colleges, youth services and primary health care services such as GPs, midwives and health visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Within this group of services we also include CAMHS delivered to targeted groups of children, such as those in care.

Specialist services work with children and young people with complex, severe and/or persistent needs, reflecting the needs rather than necessarily the ‘specialist’ skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 of the conceptual framework (though there is overlap here as some Tier 3 services could also be included in the ‘targeted’ category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRUs), special schools, children’s homes, intensive foster care and other residential or secure settings.

The levels of service described in Every Child Matters, of *universal*, *targeted* and *specialist* do not map readily on to the four tiered structure. A targeted service, for example a service that works solely on the emotional well being of looked after children (LAC), may span two or more tiers.

Furthermore, a specialist mental health service could be offered by a multidisciplinary team of primary mental health workers (Tier 2), a multidisciplinary community service (Tier 3), or could comprise highly specialised care in a psychiatric unit (Tier 4). It will take time for the firmly embedded language of tiers to disappear, so we need to find a way of including both frameworks, without adding unwieldy complication. We have attempted to do exactly that, by adapting the well used pyramid that illustrates the tiered framework mapped on to the ECM categories integral to it.



Look at the slideshow available on the CD 'CAMHS Framework', then come back to this workbook.

Language and terminology

The term *mental health* is seen by some people, including some young people, as negative and stigmatising. Furthermore some children and young people have expressed a dislike for the acronym of CAMHS and the association of many health based CAMHS with hospital settings. (It is important to note, though, that not all children and young people necessarily share these views.) One response has been to adopt the terms *emotional well being* and/or *psychological well being* and this is the language being used more commonly across children's services. On the one hand the use of this terminology can be seen to reduce stigma and perhaps to de-mystify psychological problems. Conversely some feel it dilutes the meaning and that we should instead direct our efforts to making the concept of mental health better understood in its positive sense.

Some of the shift in language is connected to the move towards greater emphasis on health promotion and early intervention, dealing with difficulties earlier to prevent, wherever possible, escalation, crisis and the need for specialist services.

Conflict or compatibility? Do a straw poll among your immediate colleagues to ascertain their views about the use of terms such as mental health, mental disorders, mental illness, emotional well being, psychological well being. Record the results in your notebook and then compare your responses with the shadow learner below.

I asked a few people connected with specialist CAMHS about the different terms used. The responses varied from the world weary and cynical to very open minded. One therapist of long standing felt that emotional well being is a cop out that just denies the severity of difficulties some children have. He was suspicious about the ideology behind it and thought it might be a way of phasing out CAMHS altogether. Another experienced person thought it was just another stage we are going through and said we should all make concerted efforts to reclaim the meaning of mental health as a positive thing to aspire to. A newcomer to CAMHS simply felt that service users should be consulted widely on how they feel and the service should be guided by that. I also spoke to two young people; one had found the "label" of a mental disorder very helpful, as it legitimised (my word) his experiences of being different. The other said, "When I was going to CAMHS we never called it that anyway, we always called it The Oaks. But everyone knew what it was whatever the name was." So I guess my results were inconclusive and the dialogue must go on.

CAMHS fitness

We must be careful not to dismiss the debates around language as just a question of semantics. There is sustained focus on specialist CAMHS and its fit with other services, whether it is fit for purpose and how to make it fit for the future

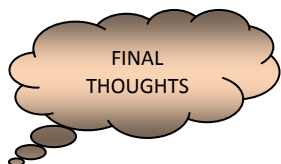
Some of the current debates revolve around how specialist CAMHS practitioners support those in universal services to promote the emotional well being of children and young people. How much time should a practitioner expect to spend on consultation and training, what skills and knowledge are required to conduct consultation and training and how can we measure the effectiveness of these processes?

The challenge to established practice

Much of the work of specialist CAMHS took place, until quite recently, in clinics that often were based in health centres or hospitals, including psychiatric hospitals designed primarily for adults. Now there is an expectation that the service will be delivered in places more congenial and convenient to users, including schools, children's centres, neighbourhood centres, and so on. Outreach into familiar settings, including people's own homes, is increasingly common.





Ways of working have also changed, from the sense of "doing to" to doing with and this has been accelerated by the increased requirement that children and young people should be active participants both in their own care, but also in wider service planning and development.

There is greater transparency and accountability. Services are specified and documented by local commissioners, setting clear targets and outcomes to meet the needs of the population. Specialist CAMHS throughout England are reporting routinely on outcomes and finding creative and innovative ways to meet increasing demand.



The people who work directly with, and in support of, children, young people and their families can make great differences to their lives. Most are passionate about doing so. They should be respected and supported and have the confidence, pride and capacity to make a positive difference for all children, especially the most disadvantaged.

To meet our ambition that this should be the best country in the world for children and young people to grow up in, everyone in the workforce in 2020 will need to be:

-  Ambitious for every child and young person
-  Excellent in their practice
-  Committed to partnership and integrated working
-  Respected and valued as professionals.

Department of Children, Schools and Families, 2008

The Specialist CAMHS Team















“Capable of working under pressure, meeting deadlines and dealing with staff and service users under stress.”

CAMHS practitioner person specification

Who’s who and how many




Information about CAMHS (and other children’s services) is collected annually by the national children’s services mapping exercise. From the mapping we can see the make-up of specialist CAMHS across England by professional group.

There are 14 different disciplines recorded for specialist CAMHS:




-  Administrators
-  Clinical Psychologist
-  Doctors
-  Educational Psychologists
-  Family Therapists
-  Managers
-  Nurses
-  Occupational Therapists
-  Other qualified (including teachers, youth workers, etc)
-  Other qualified therapists (such as adult mental health practitioners, etc)
-  Other unqualified (health care assistants, etc)
-  Primary Mental Health Workers
-  Psychotherapists
-  Social Workers

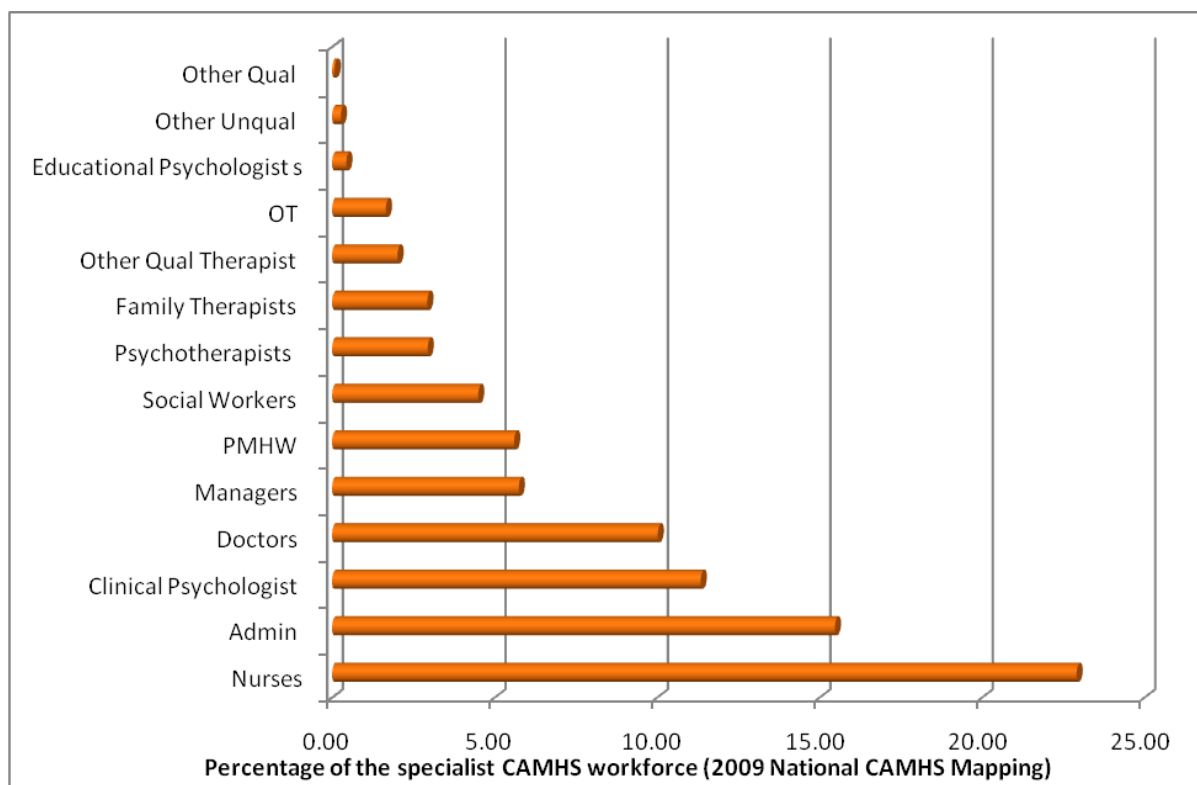
Try to guess what proportion of the total specialist CAMHS workforce is accounted for by each profession. If you find it too challenging, jot down in your notebook the three disciplines that account for the greatest proportion of the specialist CAMHS workforce and the three that account for the lowest proportion. Then look at the graph below to check your answers.

The highest in number are:

-  Nurses
-  Administrators
-  Clinical psychologists

The lowest in number are:

-  Other qualified
-  Other unqualified
-  Educational psychologists



Source: National CAMHS Mapping 2009










What strikes you about the graph? Does anything surprise you? How do you think it will look in, say, ten years time?

The figures are calculated to include Tier 4, or highly specialised CAMHS, in which the proportion of nurses is higher than in community services. If we took Tier 4 out of the calculation nurses would still account for the highest proportion but not by as much. You may have been struck by the number of administrators – their importance to the functioning of the service could be overlooked, but they are a significant element of the specialist CAMHS workforce. Both educational psychologists and social workers are interesting categories, as they are often employed by local authorities and seconded to CAMHS.

In the future we will probably see the other qualified and other unqualified categories expand, possibly re-named and, indeed, there may be new categories added. These changes will occur as new workers are attracted to CAMHS and as services develop new ways of working that require a different balance of professions and disciplines. Youth workers, teachers and counsellors, by taking additional training, will be some of the new professionals working in specialist CAMHS, but services will also be adopting a policy of “grow your own”, in which support staff and potentially service users will be encouraged to develop their skills on a career pathway.

The contribution of each discipline

Everyone in specialist CAMHS is expected to be competent in the core functions, upon which this induction is based. These are:

-  Effective communication and engagement with children, young people, their families and carers
-  Assessment
-  Safeguarding and promoting the welfare of children
-  Care co-ordination
-  Promoting health & wellbeing
-  Supporting transitions
-  Multi-agency working
-  Sharing information
-  Professional development and learning

In addition each particular discipline brings its own perspective, based on theoretical models and underpinning principles. The multidisciplinary teamworking of specialist CAMHS is a key aspect of its functioning, embracing diverse approaches, finding synergy between different understandings and bringing a richness to the assessment and treatment of children and young people with mental health problems.

The information provided below has been obtained from each group’s professional association. It describes the core skills and functions for the main disciplines found in specialist CAMHS. For more detail about competence and occupational standards for professional groups, you will need to visit the Skills for Health website by following the link in the References section.

Professionals you are likely to find in a specialist CAMHS team:

Clinical psychologist

Nurse

Occupational therapist

Primary mental health worker

Psychiatrist

Psychotherapist

Social worker

Systemic/Family therapist



Clinical psychologist

Function:

Formal, structured assessment eg standardised psychometric instruments, systematic interviewing. Evidence based therapeutic techniques including CBT with a range of individuals in distress.

In these specific areas:

Challenging behaviour, Anxiety, Mood, Adjustment to adverse circumstances/ life-events, eating disorder, Psychosis, Use of substances, Physical health problems, Psychosexual, Developmental, Personality, Cognitive and Neurological presentations

<http://www.bps.org.uk/professional-development/nos/units.cfm>

Registered Mental Health Nurse

Function

Registered mental health nurse (RMN) may work with clients in their own homes, or in residential units. Mental health nurses liaise with psychiatrists, occupational therapists, GPs, social workers and other health professionals to plan and deliver care using a multidisciplinary client-centred approach.

Coordinating the care of patients;

Liaising with patients, relatives and fellow professionals in the community treatment team and attending regular meetings to review and monitor patients' care plans;

Visiting patients in their home to monitor progress;

Assessing patients' behaviour and psychological needs;

Identifying if and when a patient is at risk of harming themselves or others.

<http://www.amicus-mhna.org/educat.htm>

School nurse	
<p>Function:</p> <p>First point of contact for health advice/ information for children, young people and parents/ carers. Assessing individual needs, offering care and treatment, and referring on to other services as necessary (eg 'drop in' sessions in schools). Supporting children and young people with ongoing or specific health needs, including complex health needs or a learning and/or physical disability. Includes direct care and treatment, promotion of self care, supporting parents and carers, referral to other specialists and co-ordination of a range of services. Public health activities across the school and community, include contributing to Personal, Social and Health Education (PSHE) delivery, working with the school to achieve the Healthy School Standard or advising on whole school programmes to address particular issues e.g. sexual health, healthy eating, emotional well being.</p>	<p>Wider role</p> <p>Good networks and working relationships with other health and social care professionals. Liaison with health visitors, speech and language therapists, paediatricians, specialist nurses for children with complex health needs, GPs, practice nurses, psychologists and mental health workers. Good working knowledge of other statutory agencies and voluntary organisations such as early years' provision, youth service, Connexions, On Track, the Teenage Pregnancy Strategy, youth offending teams, drug action teams, social services and police. Collaborative work with other agencies eg, undertaking parenting groups with youth workers or working with CAMHS workers to support young people with mental health problems.</p>
www.nmc-uk.org	

Occupational therapist
<p>Function:</p> <p>OTs working in medical settings can contribute important social care knowledge to the management of disease and illness, a valuable source of information about third sector resources and promote the health and social benefits of purposeful activity. Reduce the need for care packages. Many social services departments are finding that patients who are referred to an OT are less likely to need a complex and expensive care package. Reduce reliance on drugs and minimise the impact of drug-related side-effects and dependency. Manage behaviour that challenges services, helping people achieve positive outcomes e.g. reducing risk of self harm or violence – especially those living in challenging environments such as prisons, care homes and hospitals during long-stay visits.</p>
http://www.cot.co.uk/Homepage/About_Occupational_Therapy/Promoting_occupational_therapy/Benefits_of_OT_in_multi_disciplinary_settings/

Primary Mental Health Worker
<p>Function:</p> <p>Support and strengthen universal CAMHS provision, specifically within Community and Primary Health Care, Social Care, Education, Youth Justice and Non-statutory sectors), in relation to early identification and intervention in children's mental health need. Promote the emotional health of children, young people and families in the community. Enhance accessibility and equity for children and families, especially excluded groups i.e. asylum seekers or refugees; homeless families. Identify mental health problems in children and young people early in their development. Work across boundaries to develop a co-ordinated response children's mental health between agencies. Facilitate appropriate access to Specialist CAMHS and other relevant provision according to need. Early intervention with children and young people and their families, in an accessible and less stigmatising environment , ie community settings and the home.</p>
http://www.camhs.org/old-camhs/PDFs/CPMHW%20-%20%20role%20of.pdf

Psychiatrist	
<p>1. MEDICAL EXPERT - integrates the knowledge, clinical skills, procedural skills and professional behaviours that are fundamental to excellent patient care.</p> <p>2. COMMUNICATOR - facilitate effective therapeutic relationships with patients, families and carers. This is essential for effective clinical practice including diagnosis and decision-making.</p> <p>3. COLLABORATOR - work in collaboration with many other professionals and agencies.</p> <p>4. MANAGER - integral participants in healthcare organizations, organizing sustainable practices, making decisions about allocating resources and contributing to the effectiveness of the service.]</p> <p>5. HEALTH ADVOCATE - in addition to delivering excellent patient care psychiatrists are committed to promoting public understanding of mental health issues and social inclusion.</p>	<p>6. SCHOLAR - engage in a lifelong pursuit of mastering their domain of expertise.</p> <p>7. PROFESSIONAL - the social contract between psychiatrists, patients and society requires that all of the above are brought together through contemporary best practice, high ethical standards and exemplary personal behaviours.</p> <p>Function:</p> <p>Clinical assessment Diagnosis of mental disorder/illness Prognosis Treatment – including prescribing Medication monitoring Physical health monitoring</p>
http://www.rcpsych.ac.uk/PDF/Core_Feb09.pdf	

Psychotherapist	
<p>Understanding the individual patient in terms of personality, history, current family and social circumstances</p> <p>Enhancement of all treatments through understanding and development of the therapeutic alliance</p> <p>Self-reflection in order to understand anxieties generated by the nature of the work</p> <p>Reflection upon team dynamics in order to understand group defences</p> <p>Reflection upon institutional dynamics in order to understand institutional defences</p> <p>Use of psychosocial treatments within a therapeutic milieu</p>	<p>Function:</p> <p>Patient-directed: face to face Assessment for the purposes of diagnosis, consultation and management Co-leading ward or community groups</p> <p>Patient-directed: indirect</p> <p>Attendance at case reviews Supervision groups</p> <p>Staff-directed</p> <p>Staff support/sensitivity groups T-groups</p> <p>Theoretical teaching</p> <p>Training courses: internal and external The therapeutic milieu</p>
http://apt.rcpsych.org/cgi/content/full/7/6/461	

Social worker	
<p>Function:</p> <p>Safeguarding Promoting social inclusion Working with diversity, encouraging cultural competence Developing participation, children's rights Family work Community based work</p> <p>In these specific areas:</p> <p>Disability, including learning disability, Excluded groups, such as young refugees and asylum seekers, homeless young people, BME communities, Vulnerable groups, such as looked after children, young offenders, Highly specialised care and institutional settings, such as prisons/YOIs, residential homes Advocacy</p>	
<p>Lindsey, C., (2005) Some Implications of the Children's National Service Framework for Social Work Practice With Regard to Child Mental Health. Journal of Social Work Practice, vol.19, 2005, p.225-234</p> <p>Walker, S., (2005) Releasing Potential — The Future of Social Work and CAMHS. Journal of Social Work Practice, vol.19, 2005, p.235-250</p>	

Family therapist**Function:**

Family interventions are effective for:

Conduct disorders

Substance misuse

Eating disorders

Second-line treatment for depression and chronic illness.

There is also good evidence for:

Childhood physical abuse and neglect, Conduct problems in childhood and adolescence, including oppositional behaviour

Difficulties and problems with attention and overactivity

Drug-related problems, Emotional disorders including anxiety, depression and grief following bereavement

Psychosomatic problems

www.aft.org.uk/.../AFTresponseTOGOODCHILDHOODINQUIRY-versionforAFTwebsite.doc

Paediatrician**Mental health competence Level 3**

Neuropsychiatric / Neuro-developmental Disorders

Behavioural Difficulties

Obsessive Compulsive Disorders

Epilepsy

Attachment Difficulties

Encopresis and Enuresis

Psychological and Psychiatric Effects of Chronic

Medical Conditions

Substance Misuse

Sleep Disorders

Paediatric competence level 3

Behavioural Paediatrics

Child Public Health

Neurodisability

Visual/Hearing Impairment

Visual Impairment

Hearing Impairment

Child Protection and Children in Special

Circumstances

<http://www.rcpch.ac.uk/Training/Competency-Frameworks>

Physiotherapist**Function:**

Mental health - taking classes in relaxation and body awareness, improving confidence and self-esteem through exercise.

Learning Difficulties - using sport and recreation to develop people, assessing and providing specialist footwear, seating and equipment.

Paediatrics - treating sick and injured children, those with severe mental and physical handicaps and conditions like cerebral palsy and spina bifida.

Community - treating a wide variety of patients at home and giving advice to carers.

Education and Health Promotion - teaching people about many conditions and lifestyle choices. This may include back care, ergonomics, taking exercise classes and cardiac rehabilitation groups.

<http://www.csp.org.uk/director/public/whatphysiotherapistsdo.cfm>

Speech and language therapist**Function:**

Collaboration with other staff/agencies

Assessment and management of communication and language

Training of other staff, parents/carers

Health promotion/prevention of future difficulties

In these specific areas:

mild, moderate or severe learning difficulties, physical disabilities, language delay, specific language impairment, specific difficulties in producing sounds hearing impairment, visual impairment, cleft palate stammering autism/social interaction difficulties, dyslexia voice disorder, selective mutism .

<http://www.rcslt.org/aboutslts/>

Working together





Managing difference is an essential aspect of a well functioning team. One of the main ways difference can become apparent is the kind of evidence that people use to support their work. A CAMHS team is typically diverse; it is likely to include psychiatrists, mental health nurses (sometimes in nurse therapist posts), and clinical psychologists. There are fewer local authority social workers embedded within teams than there were 20 years ago, but primary mental health workers, appointed from a variety of professions, are now common. The argument for retaining a multi-disciplinary team structure is to ensure the presence of a diverse range of skills necessary to effectively respond to the wide range of mental health problems referred to the team.

Occupational therapists (OTs) and speech and language therapists have therefore been increasingly employed in CAMHS teams, as have family therapists and child psychotherapists. Dieticians are often associated with in-patient units; sometimes pharmacists too, play, music and art therapists.

How team members' roles are allocated may vary considerably, as much of the evidence-base of CAMHS work is thin. Precedence – “that’s just the way we’ve always done it” – rather than evidence-based principles may strongly influence how, at a local level, CAMHS work is undertaken. This can be a source of conflict.

New to CAMHS p.25

Effective team functioning requires:

-  a clear understanding of purpose;
-  common aims;
-  clear communication and review procedures; and
-  a leadership style to support all of these

What teams have you been a member and/or leader of? Reflect on how well they worked and what the key factors were for success.

Based on your experiences so far, how does your new team or service compare with others you have known in terms of having a clear understanding of purpose and common goals? Write your observations in your notebook then compare with the shadow learner below.

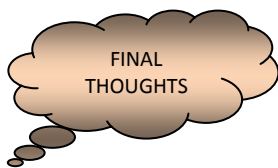
The last CAMHS team of which I was a member did not have a history of leadership. Various senior clinicians, usually the psychiatrists, had adopted leadership roles, but these were limited to offering direction in individual cases and chairing the team meetings, as well as being accountable for assessment and management of high risk cases. For team members' own development they looked to their supervisor and/or their head of profession. There was little sense of a collective approach.

When leadership was introduced more formally it was strongly resisted and in the end what pulled the team together was the use of government policy, translated into Trust procedures, which more or less forced the team to act together, as we had to formulate our vision, aims and objectives and were required to report to commissioners on progress towards those objectives every quarter. It was not an easy process, as people had been used to working in their own ways, but we had to become accustomed to sharing more openly what we were doing and how we worked.

Something the new team leader introduced was parent and young people's participation. Although many staff were sceptical and anxious, what we all discovered was that we could formulate common goals better when they were focused on what service users need and want.

Personally, what I found really satisfying was the ability to get back to the core values we all held, recognising that each of us was basing our work on those values, and working towards a shared purpose. But there were tears along the way - at first people had felt their very identity was under threat and that the hidden agenda was to "homogenise" and de-skill the team. Fortunately this didn't happen.

The shadow learner's experience highlights the need for shared purpose, based on values and informed by the users of the service. It also describes teamworking as a challenging process, in which there can be conflicts of interest. Leadership that unites the disparate elements also involves clear direction – in this case the team was informed about the areas in which they had no choice – the “must-dos” of government and employer policies and procedures.



The specialist CAMHS team is made up of diverse elements – this is at once the beauty and benefit of the service, but also potentially the source of conflict. Effective team working requires an understanding of what each of these diverse elements can contribute, then drawing them together to work towards a shared goal.

Caseload

“Supply always comes on the heels of demand

Robert Collier
American author
1885 - 1950

Your caseload

Over time you will accumulate a number of children and young people who come to you for support and care. The first aspect of your caseload you need to think about is how the cases will be allocated to you. Then the challenge will be how to manage the number of cases you are holding, including knowing when and how to close them. For both of these key aspects you will be governed to a large extent by the practice, policies and procedures of your employing organisation and of the particular team or service you have joined.

Allocation

How are cases allocated in the team or service you have recently joined? Record your thoughts and observations in your notebook, then compare with the experience of the shadow learner below.

The first CAMHS meeting I ever attended was the weekly team meeting, in which allocation of new cases was the first item of business. The chair for that day (it was a rotating responsibility) staggered in with a pile of folders. Each one contained a referral letter and some additional papers. The chair evidently had not read the files before the meeting so lots of time was spent in his scanning over the contents of each file, picking out salient points, offering quotes and distracting himself with tangential details. Then the team asked a few questions - cue more paper shuffling - until everyone was ready to say “yes we will take the case” or no we will not. At this point all the team, sitting with diaries open on their laps, avoided eye contact as the chair went round asking, “Sue do you have any time?” and “Don, would you be able to see this child” > Eventually someone would grudgingly say they would take the case and put it on the waiting list. The waiting time at that point was up to 18 months.

Allocation should be more systematic than the way it is described by the shadow learner. Many specialist CAMH services now have a single point of entry, with a coordinator for whom it is either a substantive role (in larger services) or who is doing it on a rota. At the single point of entry (or single point of referral) cases can be sifted and given an initial screening. Emergencies are dealt with in 24 hours and others are either further refined to urgent and routine, or all classified as routine.

Generally allocation meetings happen more than once a week and the coordinator, who is familiar with the referral file for each new case, leads the meeting. Allocation may be made according to the referrer's assessment of likely need, which is often described as the presenting problem and the practitioner with the most suitable skills and approach should be allocated the case. In other situations initial assessment of all cases is conducted by mini multidisciplinary teams of three or four, then allocated in light of the recommendations of the assessment.

The government sets targets for maximum waiting times between receipt of referral and first assessment appointment. Most specialist CAMHS now aim to see every routine case for assessment well within 12 weeks of referral.

Flow, demand and capacity

Matching the capacity of services to demand is important. If we do not do this we may either find that waiting lists build up (more demand than capacity) or that skilled staff are under-occupied (more capacity than demand). The latter rarely happens in CAMHS because few teams are very highly resourced in relation to the needs of their local population.

Sometimes an imbalance between demand and capacity can arise because of some factor other than excessive demand. One example of this type of situation might be where there are organisational processes in place which restrict the flow of care. In a hospital setting this may occur where the system requires the patients' doctor or key worker to make the final decision about discharge but that person is unavailable for some days because of their leave or shift patterns.

Having more demand than capacity will lead to a lengthening of waiting lists. Waiting lists may also build as a result of inefficient processes, even if there is capacity to meet the demand. Inefficient processes will also result in poor use of resources.

An excess of capacity over demand will also result in clinicians' time not being well used, whilst over rigorous processes, such as 'two missed appointments and out' will lead to clients' needs not being well met – particularly those who are hard to engage. On paper this may look good (no waiting lists) but the service is likely to be expensive and unsatisfactory to work in.

Improving flow and capacity

One way to improve flow and throughput of cases is to examine four areas:



Measuring Demand

Look at the amount of time needed for the types of appointment offered, and how many staff are involved. Assess this against the number of referrals your team receives over the course of a week. You may also need to look at seasonal fluctuations in referral rates.

Measuring Capacity

Assess the amount of time clinicians have for face to face sessions with clients. Non-client commitments may include administration, research, or consultation and training to other professions.

Activity




Look at the processes followed at each stage of the client's journey. Do all these processes make a positive contribution, ie are they necessary? Are they as efficient as they could be? Inefficient processes may cause bottlenecks in the client's journey.

Backlog




This is unmet demand which has built up, creating a waiting list. Waiting list 'blitzes' will often clear the backlog but will not help to resolve the underlying problems which led to it.

A bottleneck is any part of the system where patient flow is obstructed causing waits and delays. It interrupts the natural flow and hinders movement along the care pathway. There is usually something that is the cause of the bottleneck and acts as the constraint. This is usually the shortage of a skill, lack of equipment, or a faulty process.

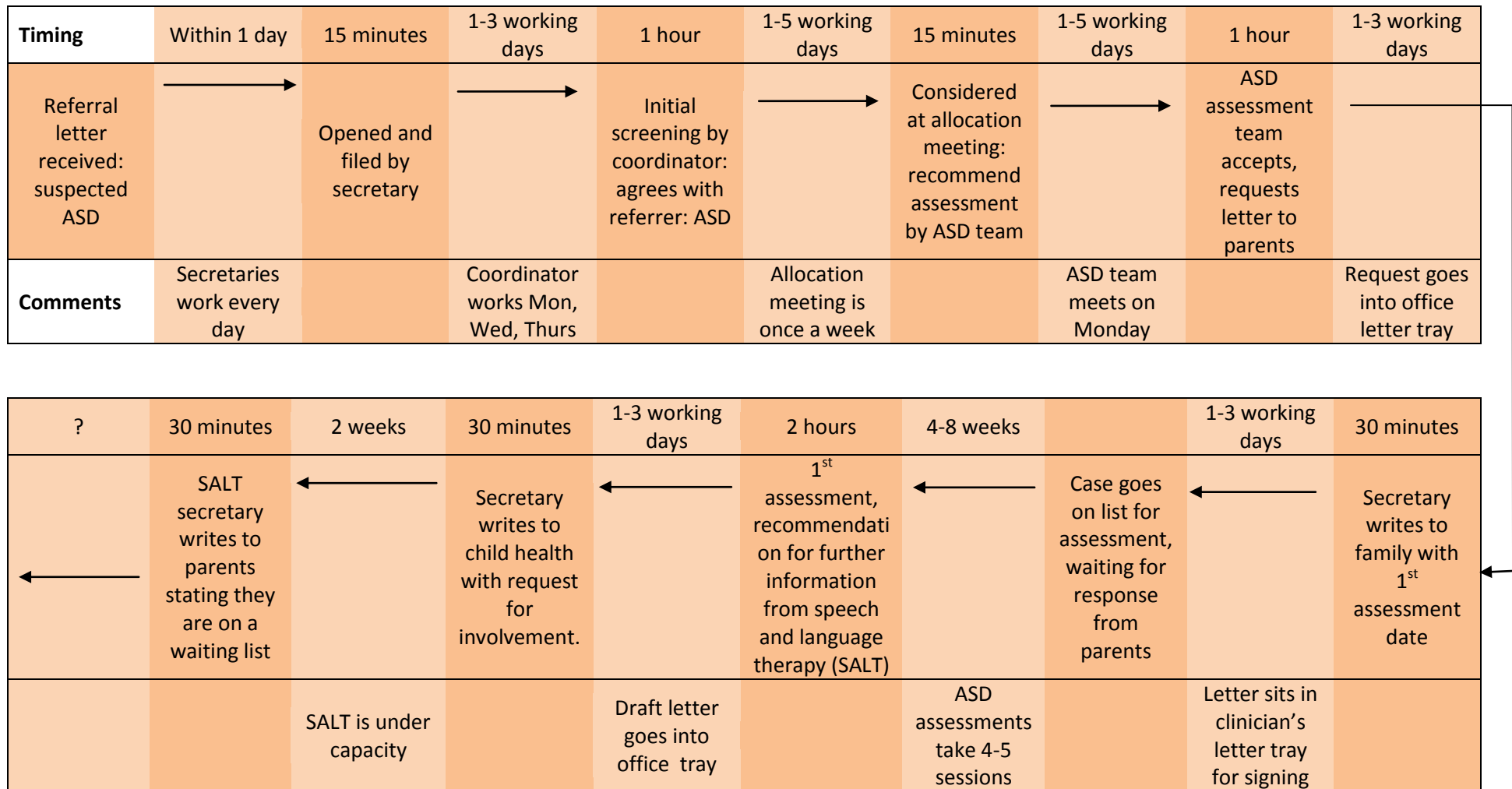
Here are some examples to help visualise bottlenecks. The first two are instances from everyday life.

-  In the supermarket there is only one till staffed by someone over 21, who can serve alcohol. On Fridays between 6 and 8 pm there is a backlog of customers having to queue at this till. The constraint causing the bottleneck is shortage of a skill, ie ability to serve alcohol.
-  On the motorway one lane is blocked off for roadworks. At rush hour the two remaining lanes are insufficient for the volume of traffic and tailbacks are created from where the three lanes merge into two (bottleneck) for several miles (waiting times, backlog). The constraint causing this bottleneck is the lack of “equipment” ie lane space.
-  In a hospital patients are not allowed to be discharged from the ward until the registrar signs the papers. The registrar can be called away for a wide number of reasons and may not appear for many hours. The people sitting on the ward with their families, waiting to go home, are a backlog and the cause of the bottleneck is a faulty process.

There is an example of a potential bottleneck in specialist CAMHS set out in a process map below. Then answer the questions below in your notebook.

-  How long would the family wait from seeing their GP to receiving an answer about the nature of the child’s problems?
-  What are the causes of the potential bottlenecks?
-  How could the care pathway be improved?

SAMPLE PROCESS MAP OF REFERRAL TO ASSESSMENT



- 📖 By our calculations, the family would wait a minimum of 8 weeks and potentially 16 weeks, between seeing the GP and getting to Stage 2 of the complex assessment, involving speech and language therapy. At these rates it could be 6 months before the family has a completed assessment.
- 📖 There are small avoidable delays in the way letters are processed – this could be improved. The longer delays are caused by insufficient skills and capacity, as well as rigid processes.
- 📖 The answer would be to bring together all those required to be part of the assessment and draw up a process map together, questioning each step to think about how it could be done more swiftly and efficiently. For example – there are aspects of the speech and language assessment that could be conducted by someone other than the qualified therapist – this would require an investment in training and supervision, but it would speed up the process by adding capacity. In a smaller way, a telephone call could be made to the parents rather than sending a letter. This would be friendlier and a more efficient way of agreeing an appointment time, also allowing the parents to ask questions about the process.

Services have tried many ways to improve the flow of care. Some have introduced systems in which routine cases have a set number of sessions, for example one assessment followed by four treatment sessions (1 + 4). These approaches create focus for both the practitioner and the clients and emphasise the positive value of working towards a discharge date. Other areas have set a standard that, for instance, for every whole time equivalent (WTE) practitioner there will be one case taken on and one case discharged every week of the year. This usually amounts to 40-50 cases per WTE practitioner, although it of course varies according to the complexity of the case and the skills and experience of the practitioner.

What are your ideas or your experiences of improving flow and increasing throughput of the caseload? Jot them down, then compare your ideas and experiences with the shadow learner below.

I visited a CAMHS with consistently high demand and really low capacity, after years of under-investment. The clinical director decided to grasp the problem with both hands. First all appointments were set at 50 minutes duration (they had formerly varied between 1 and 2 hours). Then, a weekly diary was drawn up showing each team member's availability for four days of the week - the fifth day was reserved for team meetings and admin.

Responsibility for allocating a first appointment was given to the administrators and secretaries, who contacted every parent and young person by phone. The expectation was that the majority of families would have 1+3, then there would be a review. Discharge was discussed with the family, as a positive aim, at the first appointment.

Very soon every full time member of staff was seeing in excess of fifty cases a year. The whole thing was audited and evaluated - staff reported more job satisfaction and there was no evidence of any deterioration in outcomes - quite the reverse.

Models for caseload management

One well known model for CAMHS is that of the Choice and Partnership Approach (CAPA). The CAPA approach to caseload management is summarised below:

“CAPA is about doing the right things to the right people at the right time by people with the right skills.”

The intention of CAPA is to allow CAMHS teams to put the young person and family at the heart of the service. One of the core principles is that the capacity of the service should extend to meet the demands of families waiting to be seen. There is an emphasis on how to ‘let go’ of families once they no longer need to use the service, instead of keeping families in the system unnecessarily. Within this framework, it is also important that the team manages time and human resources most effectively, and has a range of clinical skills. CAPA has eleven components, which its authors consider essential to its implementation.

CAPA has been evaluated by the Mental Health Foundation and is one of the approaches recommended in *New Ways of Working*, an influential document that has been instrumental in workforce reform.

Other techniques that have been successfully adopted in CAMHS include *Lean Thinking*. This provides another way of modelling capacity and reviewing operational processes to ensure that the processes operate efficiently and in the interests of clients.

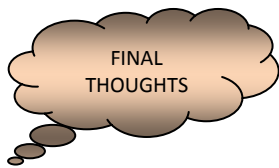
The 11 components of CAPA

1. Leadership	There is a clear working group (involving regular meetings etc) consisting 1) of an informed, helpful and present manager, 2) either a clinical lead or a clinician empowered to lead on CAPA and 3) an admin lead
2. Language	The service has changed the language and no longer refers to assessment, treatment or triage appointments but either describes these to the family as Choice and Partnership, or another local name. When considering clinical skills refers to a clinical competency not a particular discipline.
3. Handle Demand	All referrals are appropriate i.e. using eligibility criteria Families' initial Choice appointment is 'fully-booked' and The initial Choice capacity is flexed in response to referral demand.
4. Choice Framework	Initial Contact and all other appointments are in a Choice framework: Curiosity about the young person's and families view and our reflected opinion; evolving a Joint Formulation followed by a Discussion of Alternatives (not all involving CAMHS) ending in The Choice point maximised by their engagement tasks.
5. Full Booking	This means that at the end of the Choice appointment the young person and family are offered the initial Core Partnership appointment with a clinician(s) selected for their core extended skills. This requires a Core Partnership diary and ensures no internal waiting lists develop.
6. Selecting by Skill	Selecting the Partnership clinician by skill i.e. choosing the appropriate clinician for Partnership based on the family/young person's goals and chosen intervention style.
7. Extended Skills	To smooth flow through CAMHS, as well as to be as effective as we can, CAMHS needs to offer a range of intensities and complexities of intervention.
8. Goals	Each Choice should start by helping the young person and family define their goals. This will form the basis of the Care Plan. There should be frequent Care Plan reviews considering young person and family's preferences and choices. This can involve goal based outcome sheet /written Care Plans
9. Job Plans	That each individual and the team will have a job plan which include capacity, Choice and Core Partnership activity targets. Each clinicians individual plan will contains descriptions of their Choice activity, Partnership targets for each quarter, their defined Specific and other task time and supporting 'big' administration.
10. Peer group Supervision	Weekly small group multi-disciplinary peer supervision. This is in addition to individual supervision and the group supervision after Choice and Partnership clinics.
11. Team Away Days	To have team away days at least four times a year. The agenda is set by the team and involves content around clinical learning, team relationships and business issues. Management support this time and content and do not scrutinise or approve the agenda.

Using the core principles of CAPA.

Your organisation may have adopted CAPA, or like others, may have used the core principles to create a tailored version of its own. Regardless of which particular approach is adopted, the core principles are sound and are compatible with all current policy and guidance. Using these principles, rate your own service or team using the ratings sheet, this can be found in the 'resources' section of this manual.

You could share this activity with the rest of the team.



In summary, it is important that CAMHS operational processes add value at each stage and do not introduce waste or bottlenecks. Modelling demand and capacity is an essential part of this. There are various approaches which can help this process of review. Some are imported from industry (Lean Thinking), some are generic to the NHS (Improvement Leaders Guide to matching capacity and demand) and some are specific to CAMHS, incorporating elements of both other examples (CAPA).

Clinical governance

“Our children hopefully haven’t died in vain”

Parent
Bristol Heart Babies Inquiry
1995







The term clinical governance became widely used in health care following the “Bristol Heart Babies Scandal” in 1995, when the high mortality rate for paediatric cardiac surgery at the Bristol Royal Infirmary was exposed.

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system.

“A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” (Scully and Donaldson, 1998)

This definition is intended to embody three key attributes: recognisably high standards of care, transparent responsibility and accountability for those standards, and a constant dynamic of improvement.

To achieve these three attributes clinical governance is composed of the following elements:

-  Education
-  Clinical audit
-  Clinical effectiveness
-  Risk management
-  Research and development
-  Openness

If you are employed by the NHS your organisation will have a set of clinical governance policies and procedures that you will be expected to comply with. If you are a specialist CAMHS practitioner employed outside the NHS it is worth making links into professional networks to ensure you follow clinical governance guidelines that will help assure the quality and safety of your work.



Education

Some practitioners are required to undertake considerable periods of postgraduate study before accreditation; for other groups education is the responsibility of the employer and the relevant professional body. It is not considered acceptable for any clinician to abstain from continuing education after qualification, as much of what is learnt during training becomes outdated.

Clinical audit




Clinical audit is the review of clinical performance, the refining of clinical practice as a result and the measurement of performance against agreed standards. Essentially it is about checking whether best practice is being followed and making improvements if there are shortfalls in the delivery of care. A good clinical audit will identify (or confirm) problems and lead to effective changes that result in improved patient care. Particularly where there is an absence of systematically reviewed research findings, audit makes a vital contribution to practice based evidence.

Clinical effectiveness

Clinical effectiveness is a measure of the extent to which a particular intervention works. The measure on its own is useful, but it is enhanced by considering whether the intervention is appropriate and whether it represents value for money. The National Institute for Clinical Excellence (NICE) publishes guidelines and technology appraisals that recommend the most clinically effective treatments. These can sometimes be controversial, especially where pressure groups, lobbyists and individual patients or consumers, believe a treatment is not recommended because of its monetary costs. NICE works by systematically reviewing all the evidence for a treatment or intervention. Individuals with health problems often do their own research, but may not be able to judge impartially whether the evidence they find is robust and valid.

Risk management

There are risks to the patient, risks to the practitioner and risks to the provider organisation; these risks all need to be recognised, assessed and managed or minimised. To assess risk it is necessary to estimate:

-  The likelihood, or probability of an unwanted/unplanned/harmful consequence
-  The severity of that consequence
-  The impact of the consequence upon the individual and the organisation

Research and development

There is an emphasis not only on carrying out research, but also on using and implementing research and new techniques.

Openness

Processes which are open to public scrutiny, while respecting individual patient and practitioner confidentiality, and which can be justified openly, are the cornerstone of clinical governance.

What does it all add up to?


The whole point of clinical governance is that individuals and organisations have to be open- to scrutiny, to learning and growing, to sharing with their colleagues, partners and users.

How do you rate on those attributes? Look at the self rating scale which can be found in the 'resources' section of this manual and judge yourself.


Quality Assurance

Developing and maintaining a high quality service is what we aspire to. Responding sensitively to feedback, including compliments and complaints; then learning from that process, is part of the way we assure quality. Routine feedback from service users should be the feature of any organisation and for specialist CAMHS there is a validated instrument, recommended by the CAMHS Outcomes Research Consortium (CORC) and freely available: the Experience of Service Questionnaire (ESQ).

Many specialist CAMH services also participate in peer review by joining:

 The Quality Network for Inpatient Child and Adolescent Mental Health Services (QNIC)

and/or

 The Quality Improvement Network for Multi-Agency Child and Adolescent Mental Health Services (QINMAC)

QNIC and QINMAC are based on self and peer review of services using a set of quality standards; these can be found by following the links in the References at the end. The main standards for child and adolescent mental health services are the Markers of Good Practice contained within the National Service Framework for Children, Young People and Maternity Services Standard 9:

- 1) All staff working directly with children and young people have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families and to identify early indicators of difficulty
- 2) Protocols for referral, support and early intervention are agreed between all agencies
- 3) Children and adolescent mental health (CAMH) professionals provide a balance of direct and indirect services and are flexible about where children, young people and families are seen in order to improve access to high levels of CAMH expertise
- 4) Children and young people are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day
- 5) Child and adolescent mental health services are able to meet the needs of all young people including those aged sixteen and seventeen, (in cooperation with Adult Mental Health Services)
- 6) All children and young people with both a learning disability and a mental health disorder have access to appropriate child and adolescent mental health services
- 7) The needs of children and young people with complex, severe and persistent behavioural and mental health needs are met through a multiagency approach
- 8) Arrangements are in place to ensure that specialist multi-disciplinary teams are of sufficient size and have an appropriate skill-mix, training and support to function effectively
- 9) Children and young people who require admission to hospital for mental health care have access to appropriate care in an environment suited to their age and development
- 10) When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuing of care is ensured by use of the 'care programme approach'

Safety and risk

Health and safety includes providing and promoting a safe and healthy environment for staff, clients, visitors, volunteers, students, contractors and other stakeholders. There is a duty for the service to ensure it is working in compliance with all necessary Acts, regulations, CAMH safety policies and procedures, and industry safety standards.

The National Patient Safety Agency (NPSA) receives over 100,000 notifications of patient safety incidents every year from mental health services alone (it is not recorded how many are from CAMHS). The NPSA seven steps for patient safety are **BLIPILI**:

- B**uild a safety culture

- L**ead and support your staff

- I**ntegrate your risk management activity

- P**romote reporting

- I**nvolve and communicate with patients and the public

- L**earn and share safety lessons

- I**mplement solutions to prevent harm

Risk assessment

Understanding the nature of risk, assessing and managing it, are all part of clinical governance. Children and young people with severe and enduring mental health problems, particularly those who have self harmed, will usually require a risk assessment and management plan. Most mental health services use a risk profiling tool that calculates the likelihood of a specified adverse event, multiplied by the consequences; an example is shown below.

Management of risk involves engaging with the young person to identify protective as well as risk factors.

Likelihood	Consequences				
	Insignificant	Minor	Moderate	Major	Severe
Almost certain	M	H	H	E	E
Likely	M	M	H	H	E
Possible	L	M	M	H	E
Unlikely	L	M	M	M	H
Rare	L	L	M	M	H

L Low M Medium H High E Extreme

Professional ethics

Children, young people and their families put their trust in specialist CAMHS practitioners. Behaving ethically means making it clear where the boundaries to the therapeutic relationship lie and what the potentials and limitations are for assessment and treatment, so that clients have realistic expectations and understand their own roles in the process.

Each professional group and discipline has its own specific code of ethics. A generic set of professional ethics for those in public services is known as the Nolan Principles, described below.

(In 1994 the Prime Minister John Major commissioned Lord Nolan, a distinguished judge, to chair the Committee on Standards in Public Life.)

Standards for professionals in public service

Selflessness

Decisions should be taken decisions solely in terms of the client's interest and for no other reason.

Integrity

Motives must be entirely above board and not influenced by financial or other obligations.

Objectivity

All choices must be made by consideration of the known facts and not by personal preference or interest.

Accountability

Practitioners must submit themselves and their practice to scrutiny.

Openness

Reasons should be given for decisions and information shared openly.

Honesty

All private and conflicting interests should be declared.

Leadership

These principles must be supported by leadership and setting an example

Case Study – Kieran

13 – 16 years

Initially Kieran seemed to settle in well at his secondary school, although it appeared he made no friends in the first few weeks, his behaviour was not so much of a concern as it had been in his earlier schooling. It was noted that academically Kieran was bright, but teachers identified him as 'lazy'. He spent many lessons sitting in the back of class; 'dozing', and it appeared as though he was unconcerned about his education. His teachers questioned Sarah, who noted that he did not sleep well "he never has" and his noise-making during the night would often disturb the whole family.

At this point Sarah was stable on medication but was making no significant progress in terms of recovering from her depression. She told teachers that she had no idea what to do to control Kieran and that he was allowed to do whatever he wanted at home.

At school, Kieran appeared to remain unpopular with fellow pupils. There were a small 'gang' as he called them, but they had little in common and rarely did any activities together other than rowdy behaviour and intimidation of other pupils.

At the age of 14, Kieran began skipping school and finding hiding places around the city where he could go undisturbed. There were concerns that he was engaging in drug taking and other children spoke of Kieran going to a 'drinking den' rather than attend school. The police were called often to chase up his non-attendance, but he was rarely found.

Your notes and queries...

At the age of 15 Kieran was arrested for being drunk and given a formal police warning. His father again appeared unconcerned about his drinking, telling others that “he has to learn how to handle his drink and the sooner he learns this, the better”.

This arrest resulted in first formal referral to the CAMHS team.

At initial assessment at the family home, the mental health worker noted that family to be polite and helpful. Tony offered his ‘reasoned’ perspective on Kieran’s growing-up. He noted that he was very similar to Kieran, he “struggled to find his place in the world” as was something of a “free spirit”. He was certain that Kieran would eventually settle down.

The home was clean and well furnished and Maeve, who took part in the interview seemed well adjusted and very much her father’s girl. Sarah was noted to be nervous and spoke very little during the assessment.

Throughout the interview Tony took responsibility to answer questions, and did not appear to encourage too much debate about the issues raised by the referral. During the interview, he took time to chastise Kieran following a bout of swearing, threatening to ‘raise a belt to him’ if he continued. He said this was only a threat, and he “would never dream of hurting his children”.

The CAMHS worker talked with Maeve and Kieran in the assessment, who looked to their father for support in answering questions. They re-iterated all the points that had been raised by Tony. They maintained they were a happy united family, who didn’t require help. Maeve, who was 18, noted Kieran’s behaviour saying he was a wild one who’d grow up eventually, and that “boys can be slow in settling”. There did not appear to be a great bond between the children.

Your notes and queries...

A follow up appointment with Kieran was made, which he did not attend. Attempts were made to contact Kieran, who said he could not see why he had to talk with anyone if he didn't want to.

Eventually Kieran did attend an appointment and began to discuss life at home. He seemed close to his mother and somewhat protective of her, saying she was ok and that he looked after her. He had little to say about his sister, who he only called "Brains" and little to say about his father, other than he thought he was "a big know-all bully".

Kieran was mostly uncommunicative, with poor eye contact and poor verbal skills. He seemed unconcerned about his situation regarding school and the police.






It became known to the CAMHS team through a letter from a teacher, that another teacher who lived in the same street as the family that they were rarely seen out of the house. Knowing of Sarah's depression, she had tried to engage Sarah in joining a local fitness group, but was met with silence. Kieran's father was known to drink after work, but never in the local pub. The mental health team discussed this information but could not find any significant problem that they could help with. The GP appeared to be supporting Sarah- although she was not making progress.

The healthcare worker report noted that the whole family were hard to engage, despite being very polite and responsive; he noted that there was an uncomfortable atmosphere; however he felt no further contact was necessary.

Your notes and queries...





Issues/potential problems

What issues does the above raise for you in respect of:

-  Effects on the whole family of disruptive sleep patterns
-  CAMHS referral and assessments in complex cases
-  Family assessments, including sibling relationships
-  Presentation of mental health difficulties
-  Youth offending

Skills

If you were the CAMHS worker allocated to Kieran, how would you work with the network of staff such as secondary school teachers, counsellors, therapists, youth centre workers, youth offending team workers etc? Within the multi-agency context how would you as the mental health specialist contribute to the following discussions:

-  What are the issues related to the social and familial isolation of the family. What does this tell us about how this family operates?
-  What are the parenting issues related to boundary setting and discipline for Tony and Sarah?
-  Are there any safeguarding concerns?
-  The benefits of working with Kieran as opposed to the whole family.

Write your ideas in your notebook and discuss with your learning mentor or a trusted colleague.

References

CAPA

<http://www.camhsnetwork.co.uk>

DCSF (2008) *CAMHS Review: Children in Mind*

<http://www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf>

Lean thinking

[http://www.leanuk.org/downloads/health/lean thinking for the nhs leaflet.pdf](http://www.leanuk.org/downloads/health/lean%20thinking%20for%20the%20nhs%20leaflet.pdf)

Mental Health Foundation (2009) *Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England*.

<http://www.mentalhealth.org.uk/publications/?entryid5=76349&char=E>

NHS Health Advisory Service (1995) *Review of Child and Adolescent Mental Health Services: 'Together We Stand'*. London: The Stationery Office

QNIC: The Quality Network for Inpatient Child and Adolescent Mental Health Services

<http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qnic.aspx>

QINMAC: The Quality Improvement Network for Multi-Agency Child and Adolescent Mental Health Services

<http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/qinmaccamhs.aspx>

Seven steps to patient safety in mental health

<http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59858>

The children's services landscape





"Landscape shapes culture"

Terry Tempest Williams
American citizen writer
1955 -

Since 2004, with the publication of national policy and guidance under *Every Child Matters*, the children's services landscape has changed quite markedly. For example local authorities that previously separated social care from education have merged to create children's services departments.

In 2003 the Government published the Green Paper called *Every Child Matters*, alongside its official response to the report into the death of Victoria Climbié, the young girl who was horrifically abused and tortured, and eventually killed by her great aunt and the man with whom they lived.

The Green Paper focused on four key themes:

-  Increasing the focus on supporting families and carers – the most critical influence on children's lives.
-  Ensuring necessary intervention takes place before children reach crisis point and protecting children from falling through the net.
-  Addressing the underlying problems identified in the report into the death of Victoria Climbié – weak accountability and poor integration.
-  Ensuring that the people working with children are valued, rewarded and trained.

Following consultation on the Green Paper, *Every child matters: Change for children* was published in November 2004 and the Government passed the Children Act 2004, underpinning the development of more effective and accessible services focused around the needs of children, young people and families. The independent national review of CAMHS summarised as follows:

The introduction of *Every Child Matters* has encouraged more integrated working in order to deliver early intervention and preventive services. In the course of the Review, we have seen approaches ranging from the co-located multi-agency team or the 'team around the child' to the joint training of professionals in universal services so that they can better support children themselves and engage more effectively with specialist services. There are also a number of multi-agency teams around the country dedicated to addressing the needs of vulnerable groups such as children in care, children with learning difficulties and disabilities, and young people in contact with the youth justice system.






p.60

Funding and investment

Specialist CAMHS are funded mostly by the local primary care trust (PCT). The Department of Health allocates funding to PCTs on the basis of the relative needs of their populations and in line with national policy. Since 1999 there has also been an annual award by central government to Local Authorities with a requirement for consultation with PCTs prior to the funding being allocated locally. Depending on the results of these consultations, the exact contribution of local authorities to funding specialist CAMHS varies considerably.

Outcomes for children and young people

Every Child matters centres around the five outcomes, which state that every child has the right to:

-  be healthy
-  stay safe
-  enjoy and achieve
-  make a positive contribution
-  achieve economic well-being.

The outcomes are integrated and inter-dependent; for instance children and young people learn and thrive when they are healthy, safe and engaged; and the evidence shows clearly that educational achievement is the most effective route out of poverty.

Improving outcomes for all children also entails narrowing the gap between disadvantaged children and their peers. The particular focus of Every Child Matters was on outcomes for looked after children and children with special educational needs (SEN) and disabilities, and on reducing the incidence of teenage pregnancy and the number of young people not in education, employment or training (NEET).

The role of health services, including specialist CAMHS, is often interpreted locally as relating to the outcome to Be Healthy.

Which of the five outcomes do you feel your work helps children and young people to achieve?

The table below shows how specialist CAMHS may contribute to all of the outcomes.

OUTCOMES				
Be healthy	Stay safe	Enjoy and achieve	Make a positive contribution	Achieve economic well-being
SPECIALIST CAMHS CONTRIBUTION				
Promotion of mental health and emotional well being	Safeguarding work Promoting personal efficacy and assertiveness	Links with education and other agencies, schools based work	Young people's participation	Building self esteem, increasing employment chances

Children's Trusts

Prior to 2003 some local areas had already formed strategic multi-agency groups and partnerships; after the publication of the NSF (2004), supported by the National CAMHS Support Service (established 2003) there was also a drive to establish CAMHS partnerships.

With Every Child Matters came the advent of Children's Trusts. These were designed to strengthen and formalise existing partnership arrangements for children's services and could take a number of different forms, from formal agreements, with pooled funds and delegated functions (where permitted), to the sharing of staff, buildings, equipment, new technologies, information, specialist knowledge, skills and administrative support. Children's Trusts operate at every organisational level, from developing the overall strategy to delivering front-line services.

Children's Trusts have developed in different ways reflecting variation in local contexts and this has been encouraged by the government. Some perform a largely co-ordinating and cohering role, whilst others are commissioning organisations.

Children's Trust Boards

Children's Trust Boards provide the interagency governance to bring partners together in a common strategy through the Children and Young People's Plan (CYPP). The Children's Trust Board prepares and monitors the implementation of the CYPP – but does not deliver it. Delivering the strategy remains the responsibility of the partners, both individually and together. Each partner within the Children's Trust retains its own functions and responsibilities within the wider partnership framework.

Locate a copy of your local CYPP and identify the contribution to outcomes for local children and young people that your team or service is required to make. Find out how many of your colleagues are familiar with it.

Re-conceptualising children's services

Another important change post 2003/4 was the strategic framework for children's services that introduced the three levels of service provision: universal, targeted and specialist (see section 3A for more on frameworks and structures). The significance of this framework is the emphasis on extending and improving universal services, so that all children and young people can achieve the five outcomes. In terms of mental health services this has led to greater investment in mental health promotion and early intervention, with the aim of preventing escalation of problems and reducing the need for specialist services.





Part of the health promoting approach has been a challenge to the term "mental health", which many young people and professionals find stigmatising. Many agencies now prefer to refer to emotional or psychological well being, though for some specialist CAMHS practitioners this is problematic, as the terms do not describe adequately those situations in which there is a recognisable mental disorder or mental illness present.

The authors of the independent review of CAMHS (DCSF, 2008) state:

We share the World Health Organization's view that mental health is the foundation for well-being and effective functioning, for an individual, for a community and for society as a whole. Any child or young person who is not in this state of wellbeing is at risk of poor mental health. We use the term 'psychological wellbeing' to include emotional, behavioural, social and cognitive attributes of wellbeing. Both terms are consistent with the terms used in the National Service Framework for Children, Young People and Maternity Services (p.15)

For specialist CAMHS greater investment in preventative work should have led to fewer inappropriate referrals and, many hoped, a decrease in demand. However, anecdotal evidence is that it simply revealed hidden demand and many CAMH services experienced increased referrals as well as greater complexity and severity of presentations.

The role of specialist CAMHS at each of the levels is to provide:

-  Support to staff in universal services by offering consultation, training and supervision in mental health and emotional well being
-  Mental health promotion and early intervention in community settings
-  Targeted mental health interventions within services for vulnerable young people, such as those looked after by the local authority and those in youth offending services (YOS)
-  Specialist services in a range of community settings and in highly specialise settings such as inpatient units and day services.

The Common Assessment Framework (CAF) was introduced across children's services as a consistent, standardised means of identifying children in need and ensuring they receive the appropriate services and supports. To assist in this process each child or young person who is the subject of a CAF will have a lead professional, responsible for ensuring their needs are met and for ensuring their experience of services is seamless. The lead professional provides continuity and a single point of contact for children and families.

Targeted Mental Health in Schools

In April 2008 the three-year pathfinder programme Targeted Mental Health in Schools (TaMHS) began, aimed at supporting the development of innovative models of therapeutic and holistic mental health support in schools. TaMHS is designed for children and young people aged 5- 13, who are at risk of, or experiencing mental health problems; and their families. The location of mental health services in schools is part of a wider move to change the children's services landscape permanently so that children, young people and their families have access to help when they need it, in settings that are familiar and close to them.

A pictorial representation of the children's services landscape is given below. An animated version can be seen on the slide show 'The children's services landscape'.



Changes in specialist CAMHS

While this landscape has been shifting changes have also occurred in specialist CAMHS. There are more integrated services of which CAMHS is a part; some specialist CAMHS now offer outreach, crisis intervention, home treatment and services in locations such as children's centres, GP clinics and voluntary sector settings.

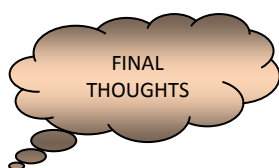
Interview an older colleague to find out how specialist CAMHS has changed over the past 15-20 years. How does your colleague feel about the changes?

The future for specialist CAMHS

Some questions that have vexed professionals for years will probably continue: should specialist CAMHS sit within children's services, or mental health services, or can CAMHS straddle both? Will the recent investment in universal services and early intervention be matched by better funding for secondary and tertiary care for child and adolescent mental health? Should there be an entirely new conception of CAMHS, sitting within integrated child and youth services? What will the future CAMHS workforce look like?

The answers to these questions will be influenced by wider government policy and economic conditions, but you might wish to consider how individual practitioners and professional groups can shape that agenda.

Perhaps the single most important influence on the shaping of specialist CAMHS in the future will be the burgeoning participation movement. Adult mental health services have for many years supported and been informed by service user and carer involvement. Now, mental health services for children and young people are beginning to embrace the idea that service users have a right to be involved in the way services are planned, developed, monitored and evaluated. As the voice of service users becomes stronger many of the dilemmas and debates will be resolved by people power.



The landscape is shifting and changing, sometimes quite imperceptibly and slowly, at other times suddenly. What should remain the same are the core values of wanting to support children and young people to live satisfying and fulfilling lives.

Local partnerships and commissioning

“Creativity is the power to connect the seemingly unconnected.”

William Plomer
South African poet and racial equality campaigner
(1903 – 1973)

Partnerships

For the past two decades partnerships have characterised children’s services and indeed much of the public services in general. What is their purpose? What do partnerships contribute that could not be achieved by the cumulative effects of each agency separately?

In your own local area you may be aware of a children’s strategic partnership (CSP), which will be the major partnership for children’s services, of which all others are a sub-set. In some places the Children’s Trust has replaced the CSP. The CAMHS partnership is informed by the wider strategy of the CSP and may include members from the local authority, youth offending, youth services, voluntary sector, child health, as well as the commissioners and providers of specialist CAMHS. The variety and diversity of these partnerships across the country – in terms of their names, membership, role and function – is too broad to be described fully here.

At some point you need to find out what your local CAMHS partnership is called, who the members are, and what impact it has on your service.

Think of partnership as working together for mutual benefit. Reflect on times when you have been in a partnership and think about the experience, its advantages and constraints. Compare your thoughts with those of the shadow learner below.

I belong to a team at work. We have teambuilding events from time to time and have a team profile that shows all our preferred roles and functions. It helps us stay focused and clear about what the team is trying to achieve as well as our personal goals. Our performance is measured by the team leader, who is also the manager of the service. I get on with some team members better than others, but on the whole it works.

I sometimes deputise for the manager by attending the CAMHS partnership. The partnership has far too many members to ever function as a team and it does not appear to have any conferred leadership, although it is very well chaired by someone from the PCT. Not all members attend every time so you never have exactly the same group and it is difficult to maintain continuity and momentum.

We belong to a team to ensure the service goals are achieved. The partnership seems to exist because people volunteer to be there?

Draw a line down a page of your notebook to create two columns, one labelled *Teams*, the other *Partnerships*. Under each heading list the features of each, based on your own experience.

Compare your thoughts with those below.

TEAMS	PARTNERSHIPS
Must have a leader	Leadership is voluntary or elected (chair)
Leader has authority	Nobody has authority or power over others
Members can be dropped (eg England cricket or football teams?)	Difficult to exclude or be excluded
Clear overriding purpose	Collective goals do not override individual ones

Whilst partnerships may benefit from the processes and techniques used in team development, they differ in fundamental ways from teams. Teams are put together to achieve the overriding goal and whereas partnerships need to establish shared goals, the members will always have to attempt to reconcile these with their own agencies' requirements and criteria.

This is why partnerships can become complicated and difficult.

There are of course features that teams and partnerships share in common, such as an emphasis on diversity and collaborative working.

According to the Audit Commission (2002) the essentials of partnership are:

 Performance

 Inclusion

 Probity

Performance includes the need for terms of reference – why does the partnership exist and what is its purpose? Significantly performance also implies that the partnership must produce outcomes that add value, so that results are achieved by the collective that amount to more than the addition of all the members' actions individually.

Inclusion means that careful consideration must be given to membership; the problem that arises is the more inclusive the membership, the bigger the group becomes, making it harder to function. The range of services that needs to be represented should include the voluntary and independent as well as statutory sectors. Inclusion also prompts the question of how to include service users – young people, parents and carers.

Probity refers to the notion that people are members of the partnership for principled reasons, not for self interest and the work the partnership does must be beneficial to local children, young people and families.

The reality of working in partnership is that it requires systemic thinking, as described by Pithouse (2003), below:





All the key messages from government are that providers should, conceptually at least, inhabit systemic (joined up) worlds and that the critical knowledge for all of us to acquire is how to integrate our separate and specialised competences into coherent practices across a service field. This is the critical knowledge, or 'meta-competence'. Put crudely, metacompetence combines know how, know who and know what, with know why. That is, participants know why they are operating in a system and know why they need to think and act across boundaries in order to maximise service opportunities and impact. Successful organisations have staff with the skills for system thinking and working.

There is a slideshow available on the cd 'partnership working', then come back to this workbook.




Commissioning

Within the CAMHS partnership there will be a combination of commissioners and providers. The main commissioners of specialist CAMHS are the primary care trust (PCT) and local authority (LA). The function of commissioning is to ensure delivery of services that best meet the needs of the local population. Commissioners are leaders within local services and should demonstrate knowledge and skill, act with probity and inspire confidence.





The specific tasks of commissioners are to:

-  Understand local population needs and plan services to meet them
-  Procure resources efficiently
-  Evaluate service quality and outcomes
-  Benchmark provider activity against similar NHS organisations.

In specialist CAMHS the commissioners will normally:

-  Produce a service specification, which states in detail what specialist CAMHS should provide, within a defined budget, in order to achieve the best outcomes for local children and young people, based on the population needs assessment.
-  Enter into a contract with the local provider(s) based on the service specification. This may be achieved by negotiation, or by putting the specification out to competitive tender.
-  Require regular reports from the provider against each section of the contract.

The providers will normally:

-  Provide clinical expertise to illuminate the evidence for effectiveness.
-  Enter into dialogue with commissioners about local need.
-  Respond to the service specification by providing the services required.
-  Supply meaningful data that demonstrates the achievement of outcomes for children and young people.

In mature partnerships the providers and commissioners have a constructive dialogue, one that is often challenging, but ultimately respectful and dynamic. Relationships between providers and commissioners cannot be expected to be always comfortable, as each comes from a different perspective and is influenced by different drivers. However, there has to be a shared commitment to planning and providing high quality services for children, young people and their families; this is the point of common interest.

Service User Participation

“If the people who are supposed to be the beneficiaries of change do not know that it is happening – then it probably is not happening.”

Lord Herman Ouseley
former Chair of the Commission for Racial Equality

What is participation?








The UN Convention on the Rights of the Child (UNCRC) states that child participation is the right of every child. (The word child is used in the UNCRC to describe all people under 18 years of age.) The UNCRC sets out development, protection and participation rights for all children.

Article 12 states:

- States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
- For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Basically, this means that children now have the right to have a say in all decisions that affect them. This includes small day to day decisions and also larger ones. They have the right to have a say in the way services affecting them are planned, delivered and evaluated.

Different meanings of participation include:

-  seeking information, forming views, expressing ideas;
-  taking part in activities and processes;
-  playing different roles including listening, reflecting, researching, speaking;
-  being informed and consulted in decision making;
-  initiating ideas, processes, proposals, projects;
-  analysing situations and making choices;
-  respecting others and being treated with dignity

What does participation mean to you? Record your thoughts and ideas, then ask around in your team or service to discover what your colleagues think.

Compare your thoughts with the slide show available on the cd 'What is participation', which gives an international perspective on participation, as well as some quotes from young people, gathered at a consultation event in 2009.

Roger Hart's Ladder of Participation

Working on behalf of UNICEF in 1992, sociologist Roger Hart created a model for thinking about youth participation, based on earlier work by Sherry Arnstein. The "Ladder of Participation," identifies eight types of youth participation ranging from tokenism and manipulation to engaging youth as partners. It was to introduce staff to the concept of different levels of participation of inclusion groups in decision making processes.

Hart's ladder of participation is a useful model for thinking about children's involvement, how they learn, and how professionals intervene in that learning. Organisations often find themselves moving between 'rungs' on this ladder. Experience of the 'middle rungs' is often needed by children, to develop the skills that will enable them to move further up the ladder.

Rungs 1 to 4 are often seen as examples of 'non-participation' and rungs 4 to 8 are seen as 'developing participation'.

Complete the ladder on page 161 in the Self test section, to show the spectrum of participation. You will find the correct answers in the Solutions section of this manual.

Why participation?

The simple answer is that it is enshrined within our national guiding policy. The added significance is that all our current policy is based on extensive consultation – with strategists, practitioners, parents and carers, as well as children and young people.

The timeline of policy and direction below shows the first guidance from the then Children and Young People's Unit, followed by and referred to in the National Service Framework. In the progress report for the NSF we see the government establishing development initiatives, including participation. In 2008 the independent review of CAMHS highlights participation as a major theme and this is supported the next year in the government's official response. Out of the CAMHS review comes the establishment of the National Advisory Council, through which the theme of young people's participation is pervasive and explicit.

2002 Guidance by the Children and Young People's Unit (CYPU)

Included practical guidance, a range of case studies and interesting organisations for further advice.

2004 National Service Framework for Children, Young People and Maternity Services: Core Standards

Children, young people and their parents participate in planning, evaluating and improving the quality of services. User participation follows the principles set out in Learning to Listen: Core Principles for the Involvement of Children and Young People. Findings from user participation consultation, in all settings, are reviewed at Board level, reflected in improvements in services and are available to children, young people and their families. (p.91)

2007 NSF development initiatives (NSF progress report)

Involving users in their own care offers potential benefits in two key areas. First, it enables young people and their families to choose where, when and how services are delivered to them, increasing their levels of commitment to the treatment programme and boosting the chances of it achieving the desired outcomes. Second, feedback from users can inform strategic decisions about commissioning and service delivery. This is one of the key principles set out in the Commissioning Framework for Health and Wellbeing (p.37)

2008 Children and young people in mind: the final report of the National CAMHS Review

At national level, neither children and young people who have experienced mental health problems nor their parents or carers have a 'voice' (for example in the form of a service users' forum). This contrasts with the positive developments we have seen in recent years around young people's participation more generally, for example through the work of the National Children's Bureau and the establishment of bodies to provide a forum for certain groups, most notably children in care. This may be because of the stigma that continues to be associated with mental health problems. We would like the Government to explore whether a national organisation, run by parents, carers and children and young people, could be established to represent the interests of children and young people with mental health and psychological well-being needs. (p.33)

2009 Promoting the participation of children and young people: Government response to CAMHS Review







The Department of Health has commissioned the National CAMHS Support Service to carry out a project promoting the participation of children and young people. The project promotes user participation standards for CAMHS, maps the extent and level of user participation activity in CAMHS, and will develop an online tool for commissioners and providers to improve interaction with children and young people. (p.42)

2010 National Advisory Council for Children's Mental Health and Psychological Wellbeing: One Year On






We have found that young people have imaginative and well-thought-out ideas for how services can be improved; they have told us that the staff working with them should give them the opportunity to say what they think, should listen, and should take on board what is being said. We know from practice that children and young people find true participation helpful to them personally, and that it also improves services. However, we also know from practice that full and meaningful participation can be hard to achieve. This needs to change and services must be supported to ensure that children and young people are fully involved. (p.8)

Outcomes of participation

Most of the literature about children and young people's participation has focused on the processes of doing it, rather than the benefits to be gained from it. However a in a study that examined participatory practice with children and young people in 29 case studies (Kirby et al, 2003) the benefits to young people were found to include:

-  Technical skills – such as: filming, editing, website design, information technology.
-  Organisational skills – such as: presentations, facilitation, recruitment and selection, minute-taking.
-  Creative skills – such as: acting and writing newsletters.
-  Workplace skills and experience – such as: applying oneself in a working environment, adhering to guidelines, attending meetings, working in a large business environment, assertiveness, coping with stress, and time management.
-  Presentation and language skills
-  Other skills – such as: decision-making, public speaking and media relations.

A later study found that participation and involvement can fulfil a range of organisational objectives, including:

-  Improving quality and effectiveness.
-  Meeting rights and obligations.
-  Involving consumers and stakeholders.
-  Empowerment.
-  Developing skills and competencies.

How to do it? Pros and cons

Below are some examples of activities that involve young people in organisations, with the advantages and disadvantages of each.

Activity	Examples	Advantages	Disadvantages
Consultation exercises	Local or national consultation with children and young people	Consultation is focused on specific issues-less onerous in terms of long-term commitment and expectations. They can provide a useful snapshot, which may inform further work.	No ongoing involvement in the development and implementation of the product or issues they have been consulted on. Consulting repeatedly on the same or similar issues without demonstrating impact on service development or practice is frustrating for all concerned.
Children and young people websites	Can be used to post information on a range of events and services as well as posing questions for debate and feedback.	Potential numbers that can be involved. Can be multi-purpose and involve children and young people in web design and used extensively through schools, libraries and youth clubs. A well-designed website can be fun and engaging for young people.	Developing a good website needs dedicated and skilled input for set up and moderation and there is a requirement for sufficient resources.
Research	Children and young people undertaking research or co-facilitating workshops to identify issues.	This can have a direct impact and allows young people to develop their knowledge and skills in a tangible way and an opportunity to work as equals with adults.	Young people can be dismissed or patronised by adult and gives an opportunity for just a small number of children and young people. Adults often take over the results and work may not be properly rewarded.
Large scale events	Young people's conference event, which can then be used to elect representatives to be on smaller advisory groups or committees.	A larger event can be more inclusive and encourage a sense of shared identity and purpose and generate a great deal of energy and enjoyment. A great deal can be achieved quickly.	Huge preparations and planning task requiring time and money. This approach raises the stakes in a very public way and therefore needs good follow up and a realistic commitment to action.
Group meetings	Strategically linked groups meeting on their own territory but with a support worker who links across all groups in the network and raises issues on their behalf.	A good way to link up and support hard to reach groups which provides regular and consistent involvement in a familiar safe environment, with time to develop ideas.	Needs a great deal of support worker time, there is no direct authority and change may seem remote.
Advisory groups	Groups of children and young people, and possibly adults, brought together to advise and inform planning, delivery and review of a piece of work or a project.	Opportunity to really influence developments and have some ownership.	Can be time-consuming and drawn out, lack real authority and sometimes hard to gain regular attendance.
Having young people on committees	Children and young people are elected or selected to be part of committees or boards, with a specific number of places reserved for them.	Direct access to governance and the potential for long-term influence. Requires significant change in organisational attitudes.	Are young people really treated as equals? Danger of tokenism. Representatives can be required to represent views of all young people rather than serve in their own right. Significant staff resources are required to support and ensure proper access.

Golden rule

Even at the simplest level of asking young people about their suggestions for service delivery, it is essential to demonstrate to them that their voices have been heard. One way is to have an information board on display, which can be set out very simply like the example below.

<i>what you said</i>	What we did
<i>We want to choose our own meals</i>	We appointed a nutritionist to work at the unit with you, to talk about planning meals. We have weekly meetings with the chef to let you help plan the meals for the week.
<i>We need more places to do our homework</i>	We have ordered some new desks for the art area, they will arrive in 2 weeks

Below are some examples from an information board at a Unit in the West of England which was very successful with the young people who were staying there.

<i>What you said?</i>	<i>What we did?</i>	<i>How have things changed?</i>	<i>What was not possible?</i>
<i>We want more activities available</i>	We looked at what is available near to the Unit, and got some leaflets for people to look at	There is now the opportunity for young people to attend the local gym	It is not possible for everyone to do a different activity as there are not enough staff
<i>We want to choose our own bedtime</i>	We held a meeting for everyone to talk about this	We agreed that people would be able to choose their own bedtime (within reason) after talking to their nurse	It will not always be possible for young people to go to bed exactly when they want, but we will always discuss things with you
<i>We want to be able to use a computers at the unit</i>	We looked at the costs	We are now buying a computer for the Unit which we will have in about 3 weeks	We could not buy a computer for every person
<i>We would like more outdoor space</i>	We walked around the site with the young people and looked at possible areas that could offer them more space	We found part of the car park that was not being used, and we are going to make it into an allotment for the young people	We could not buy a large climbing frame as it was not safe and there was not enough room
<i>We want more places to meet our families</i>	We are looking at this problem	This needs more work, we will discuss this again at the house meeting next week	Still working on this

What are you going to do to involve children and young people in participatory practice? Record your ideas in your notebook and discuss with your learning mentor or supervisor.



The National CAMHS Support Service records these views from young people about participation:

I feel empowered to be involved in decision making

It can lead to improved services. Adults don't always know best!

I have more self esteem because I feel I can affect change

Inter Agency Working

“Specialist CAMHS need to work closely with other service providers.”

Audit Commission 1999

Multi-agency and inter-agency working

The definition of the prefix *multi* is: consisting of multiple elements or constituents.

Multi-agency therefore refers to many agencies.

The definition of the prefix *inter* is: among, between, connecting.

Inter-agency therefore means connected agencies.

The variety of service providers include:

1. In the statutory sector, both ‘universal’ (i.e. primary care, education, social services, community child health) and ‘specialist’ (e.g. CAMHS, educational psychology etc).

2. In the community many non-statutory agencies have developed highly-regarded

projects (e.g. Barnardos, NCH etc).

The current plethora of service providers has created many new opportunities for young people, but the diversity of the range of potential help can also produce uncertainty or confusion about where and how a problem is best addressed.

Joined-up working is a widely-agreed principle, but important practical problems remain:

- Concerns about the confidentiality of shared information.
- Multi-disciplinary working in some CAMHS has been difficult to maintain for practical reasons, e.g. skills shortage, etc.
- Except for educational problems and child protection concerns, there are few integrated care pathways and still fewer assessment tools to determine down which path a particular problem should be directed.

New to CAMHS p.21

It is increasingly recognised that to improve the ability of child and adolescent mental health services to provide effective care to children and young people, it is necessary to strengthen the support CAMHS provide to other services, such as schools. This requires multi-disciplinary teams and inter-agency working.

Think about the range of organisations that you as a specialist CAMHS practitioner need to work with, then consider the factors that facilitate joint working. These have been summarised on the slideshow called ‘Joint Working’, take a look, then come back to this workbook.

It is critically important that professionals understand the roles and responsibilities of partners in other agencies, and participate in joint training to build a common purpose, language and strategies. Issues of consent, confidentiality and information sharing can interfere with good inter-agency working, and processes must be developed to address these difficulties. Multi-agency training helps to ensure there is a common language and understanding, as well as fostering mutual respect for other disciplines and approaches.

Children and young people and their carers need access to a range of interventions that provide support, training and advice for both carers and parents and the professional network around the child, as well as direct interventions with the children and young people. Think about all the organisations you regularly work jointly with.

Write down some of the positive aspects you have experienced of working jointly with other organisations, but also think about some of the challenges when working with others. Compare your notes with the shadow learner

I ran a project to set up a multi-agency service across two geographical areas. It was extremely challenging, despite the fact that (almost) everyone was signed up to the project and wanted the best for local young people. One obstacle was dealing with the perceptions and stereotypes that a few people held about specialist CAMHS - one person used to talk about their easy life dealing with "bed wetters", while the rest of the children's workforce was working "at the sharp end". It was difficult to challenge firmly held views or prejudices, other than to let our actions speak louder than our words, by for example, taking on young people with challenging behaviour and very complex needs. Even among health colleagues, CAMHS was seen as a bit mysterious.

Often we realised we were using different professional languages, so what CAMHS called a conduct disorder, social care colleagues referred to as very challenging behaviour and education as disruptive behaviour. And we all referred variously to the same child as having "learning disability", "learning difficulties" and "special needs".

It was not an easy process, but through it I learned the importance of identifying, then holding on to the shared goals, as these were what did unify the group even when everyone seemed to have disparate interests. It was also clear to me that without strong backing at a very senior level from each of the host organisations, our project would never have got off the ground.

Benefits of joint working	Issues to be addressed to make joint working productive
Generates enthusiasm	Issues regarding consistent procedures, protocols and working practice
Increases awareness and interest in the area	Location of joint services
Staff acquire more and different skills	Need a fully integrated joint working policy
Better range of help in crisis situations	Need robust joint working agreements
More available resources and information	Services need to be jointly commissioned
Closer collaboration encourages shared aims and purpose	Conflicting models of service alignment and delivery
Uses shared expertise and resources	It is vital that joint working is closely monitored to ensure its effectiveness
Professionals in all services can think beyond their discipline to support the whole family where a parent, child or young person has mental health difficulties	

Joint working: research

Below is a short extract from the findings of a study looking at the impact of joint working (Department of Children, Schools and Families, 2003).

Joint working: Impact, Advantages and Disadvantages

Impact on children

Overall many respondents, especially school staff, acknowledged that joint working had resulted in an increase in children's happiness and well-being. There was a measurable improvement in children's behaviour in two of the services, and better peer relationships were identified by workers. Although rarely measured, workers identified links to improved academic attainment, as children were able to learn and were developing learning skills. Education staff identified impacts on exclusion of children as their behaviour changed, or that they were allowed thinking space before being excluded. This was not being measured formally by the interventions. Some examples of work with school phobics showed improvements in school attendance.

Impact on staff

Working more closely increased awareness and learning between health and education staff. Education staff felt they had increased access to mental health services and a greater understanding of the services available. Health staff reported having a greater understanding of the school context and the impact it may have on children's mental health, staff, and educational resources.

Impact on service delivery

CAMHS staff felt that they were accessing children who would not normally be reached and identifying children's problems early. The services were felt by staff to be more accessible to parents and children as they were physically easier to get to, less stigmatising and within children's own environment. CAMHS workers identified that they received more appropriate referrals. Some workers felt that services were improved as they could allocate more appropriately within teams and avoided duplication of work.

Disadvantages were seen to be that this way of working was more time consuming, the potential danger of duplicating work if it is not co-ordinated effectively, management problems, issues over information sharing and getting swamped with referrals. Also, practitioners working with schools felt pressured by high levels of expectation of the service.

Joint working: examples of good practice

In Barnardos services where there is more joint working and networking with CAMHS, staff have reported that language differences are less of a problem. In Birmingham, Barnardos ARCH project works closely with local CAMHS (even sharing the same building) and this has really helped to bring language and working culture in line.

Some head teachers perceive CAMHS as "remaining aloof as clinicians" rather than committing to multi-agency joint working in holistic teams. Their role needs to be clarified along with greater involvement in broader issues as it is the experience of some head teachers that it is hard to get CAMHS staff to meetings.

Some of the learning:

Different organisational and professional cultures represent a challenge to joint working. This impacts on the relationship with children, the approaches to work and understanding of mental health issues, attitudes towards children's behaviour, information sharing and confidentiality, management and accessing services. The majority of these problems were resolved by close joint working, good communication, and sharing policies.

The skills of workers and good communication were key, including the ability to work flexibly, and creatively, being able to pool professional skills, confidence in their own skills and being approachable. The importance of knowing individuals was also stressed, which has implications for longer term funding and staff retention.







Other key issues were the ways of sharing information on cases; confidentiality issues were raised and different approaches to sharing information. Spending time in school by CAMHS staff was important as it increased acceptance and knowledge both of health and school staff. However, it was important for health staff to remain part of the clinical team and receive supervision.

Thinking about the workforce in your local area, including people who work in health, education and social care across universal, targeted and specialist services, what do you think are the current issues (for example, capacity, training, joined-up working, mix of different professionals)?

Confidentiality and information sharing

For some CAMHS practitioners the major barrier to inter-agency working is that agencies have different and apparently conflicting arrangements for information sharing and this leads to a fear about compromising confidentiality.

The key points to remember about information sharing are:

-  Explain to the child what you will share and why, and seek their agreement unless this would put them or others at increased risk or might interfere with any investigation.
-  Consider the safety and welfare of the child when deciding to share information. Where there are concerns of significant harm, their safety and welfare is paramount.
-  Where possible, respect the wishes of children who do not consent to share confidential information.
-  Seek advice where you are in doubt.
-  Ensure information you share is accurate, up to date, and necessary for the purpose, shared with only those who need to see it, and shared securely.
-  Always record the reasons for your decision - whether it is to share information or not.

Many children's services share information routinely and may struggle to understand why specialist CAMHS practitioners seem less willing to share. Information sharing about a specific child or family can be a safety precaution to prevent them "falling through" gaps between services. It is essential in some areas of work such as safeguarding and in many cases, where children, young people and parents or carers are well informed and consulted, it is welcomed as a way of saving them telling and re-telling the same basic information to a number of different professionals.

The advice from the Department of Children, Schools and Families (2009) is summarised as:

7 key questions

1. Is there a clear and legitimate purpose for sharing information?
2. Does the information enable a living person to be identified?
3. Is the information confidential?
4. Do you have consent?
5. Is there sufficient public interest?
6. Are you sharing appropriately and securely?
7. Have you properly recorded your decision?

N-STRAP

Necessary – Secure, Timely, Relevant, Accurate, Proportionate

Confidentiality








Under the European Convention on Human Rights, children and young people have a right to confidentiality. A case by Gillick established the concept of increased competence to make decisions as children matured (Gillick competence is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge).

The Department of Health has produced a useful booklet about consent and young people, providing guidance to healthcare practitioners on how to seek consent from children in their care. Part one focuses on the issue of 'competence'. It considers situations in which children may be unable to give consent themselves. It explains who is legally allowed to give consent to care or treatment on a child's behalf. Part two looks at situations that may arise when seeking consent.

They range from straightforward issues such as the use of consent forms to more complex matters such as parental disagreements. The final section covers consent to treatment for mental disorders and consent to a child's involvement in therapeutic or non-therapeutic research. Brief, illustrative examples are provided at the end of each section. There is also a concise source list of further information and guidance.

Protecting confidential information

Professionals will often need to share information about young people, if cohesive joint working is to be achieved. It is also acceptable to talk to colleagues about cases and ask for advice, but you should keep your talks anonymous and only discuss the necessary facts.







-  You must make sure that you protect personal information about all young people (and others, including carers and colleagues) against improper disclosure at all times.
-  You must not discuss identifiable young people unless in exceptional circumstances.
-  When discussing young people you must ensure that you cannot be overheard by anyone not bound by the same requirements of confidentiality towards that young person.
-  You must not leave material containing personal data, either on paper or on computer screen, where it can be seen by other young people, unauthorised staff or other visitors.
-  You must keep all portable records containing personal data in recognised filing and storage places. This storage should be locked at times when access is not directly controlled or supervised.
-  You should switch off computers with access to client information, or put them into a password-protected mode, when you are not working on them.
-  From time to time, you may need to keep material with personal identifiable data in places other than a locked cabinet. You must keep all such material under secure conditions

Integrated services






Some areas have opted for integrated services, where there is a one-stop shop for all young people and their families to go for help and support in a place and at a time that is suitable for them.

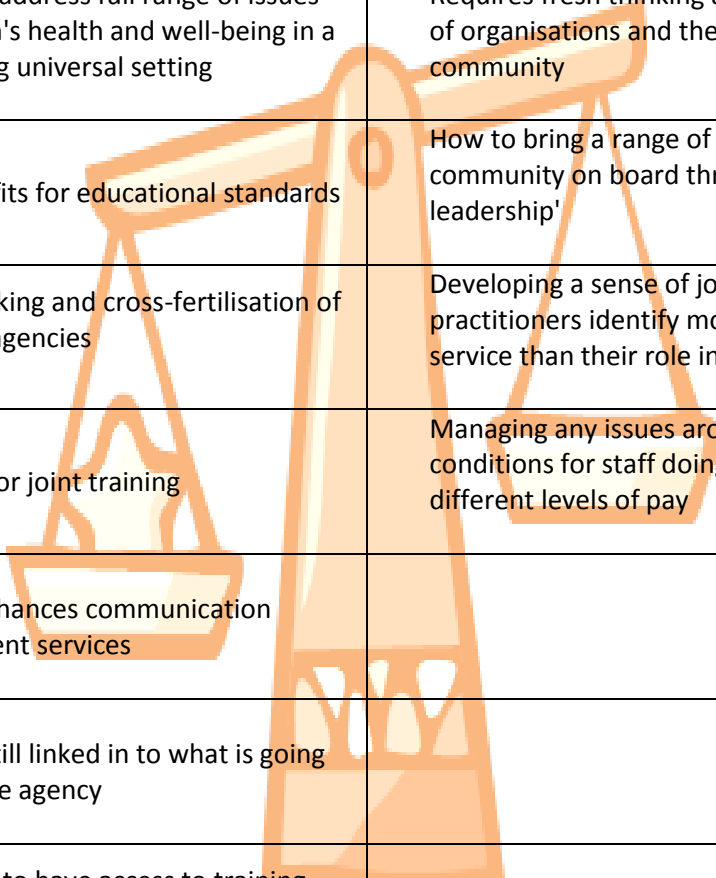
The key feature of an integrated service is that it acts as a service hub for the community by bringing together a range of services, usually under one roof, whose practitioners then work in a multi-agency way to deliver integrated support to children and families.

Key features of an integrated service

-  It is made up of a range of services that share a common location and a common philosophy, vision and agreed principles for working with children and families
-  It is a visible 'service hub' for the community, with a perception by users of cohesive and comprehensive services
-  It has a management structure which facilitates integrated working
-  There is a commitment by partner providers to fund and facilitate integrated services
-  Staff work in a coordinated way to address the needs of children, young people and families using the service. This is likely to include some degree of joint training and joint working, perhaps in smaller multi-agency teams
-  Service Level Agreements (SLAs) set out the precise relationship between the home agency and the multi-agency service, including the basis on which staff are employed

Services may include:

-  Access to high-quality, all-year-round, inclusive education, care and personal development opportunities for children and young people
-  Multi-agency teams to provide specialist advice and guidance to children, young people and families on aspects of health, social welfare and employment
-  Outreach services to support local families with additional needs
-  A family support programme to involve and engage parents and carers in their children's learning and in the day-to-day life of the service
-  A framework of training strategies for practitioners



Benefits and opportunities	Challenges
Opportunity to address full range of issues around children's health and well-being in a non stigmatising universal setting	Requires fresh thinking around the concept of organisations and their purpose in the community
Knock-on benefits for educational standards	How to bring a range of partners and the community on board through 'collaborative leadership'
Greater co-working and cross-fertilisation of skills between agencies	Developing a sense of joint purpose so that practitioners identify more with the new service than their role in their home agency
Opportunities for joint training	Managing any issues around pay and conditions for staff doing joint work at different levels of pay
Shared base enhances communication between different services	
Members are still linked in to what is going on in their home agency	
Members likely to have access to training and personal development in their home agency	

Check your understanding so far by going to Self Test 4d on page 162. The suggested answers can be found in the 'answer' section.

Case Study – Kieran

16 – 18 years

Kieran left school at age 16 with no formal qualifications. Maeve had left school following 6th form and got a place at a good university to study Chemistry. There appeared to be little contact between them. After a few months at home, with no prospect of work, a major disturbance erupted at home. Police were called to a domestic situation which resulted in Tony insisting that Kieran move out telling him to “become a man”. The police escorted Kieran from the house with a bag of clothes and two pairs of trainers.

Kieran started sleeping on friend’s sofas, moving around the country going where someone would give him a bed. His parents rarely had any idea where he was staying or who he was staying with.

Eventually Kieran ended up living in a squat with a number of other young people, mainly young men around his age many of whom had run away from home or had been released from prison.

Kieran’s family at first missed seeing him at important family occasions, initially his mother was upset that he wasn’t there for Christmas dinner and bought him some presents that she put for him under the Christmas tree, but soon it seemed to everyone that she had lost interest in him.

At first there were family photos on the window sill that showed Kieran and his sister, but as time moved on the photos were replaced and pictures of Maeve completing her college course and her university degree took pride of place.

Your notes and queries...

Case Study – Kieran

Postscript

Kieran is now 24, and he is a well turned out and polite young man. After being evicted from the squat he was living in he slept rough for a while and eventually started visiting a night shelter in the city centre where he came into contact with Matt, a local youth work co-ordinator.




Over time Kieran began to trust Matt (although this took quite some time and there were many disagreements), Matt went with Kieran to the housing office and helped him with organising the rental of bedsit near the city centre. He helped him to apply for decorating vouchers and furniture coupons to furnish the bedsit.

Matt also encouraged Kieran to get in contact with his family. He started by meeting his mother for a coffee in the town centre, and met his sister for a drink a few weeks later. He is now in telephone contact with his parents on a fortnightly basis, although he rarely sees them. He did go home on Mother's Day, but his father ended up talking about his sister all the time and telling Kieran he was "a bit of a disappointment to the family" which made Kieran angry so he walked out.





Your notes and queries...

Issues/potential problems

What issues does the above raise for you in respect of:

-  The age limits to services
-  Responsibility for young people in transition
-  Ways to engage and involve older young people

Final thoughts

-  What could have been done to prevent Kieran falling out of the system?
-  Did the system fail him?
-  What was the most appropriate role for specialist CAMHS?
-  What are Kieran's likely life chances?

Write your ideas in your notebook and discuss with your learning mentor or a trusted colleague.

References

Barnardo's response to The CAMHS Review: Next Steps to Improving the Emotional Well-Being and Mental Health of Children and Young People

Call for Evidence 7 July 2008

http://www.barnardos.org.uk/barnardo_s_response_to_camhs_review_3rd_july_08.pdf

Child Rights and Development project

www.iicrd.org

<http://www.iicrd.org/cap/childparticipation>

DCSF Every Child Matters: Integrated services

<http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/multiagencyworking/integratedservices/integratedservices/>

Department of Children, Schools and Families (2003) Effective Joint Working between Child and Adolescent Mental Health Services (CAMHS) and Schools

<http://www.dcsf.gov.uk/research/data/uploadfiles/RR412.pdf>

Department of Children, Schools and Families (2009) 7 key questions

<http://publications.everychildmatters.gov.uk/eOrderingDownload/01070-2008FLY-EN.pdf>

Department of Health Consent Guidance.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005762

Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL).

<http://www.careandhealthlaw.com/Public/Index.aspx?ContentID=-66&IndexType=1&TopicID=245&Category=1>

UNCRC

<http://www.unicef.org/crc/>

Induction in context

The notion of CPD is based on the idea that we need to be engaged in lifelong learning. The learning we had in the past and our current understanding will be helpful and make a significant contribution to the work we complete. However services are not static and the needs of Children and Young people are not static either. Therefore, in order to respond purposefully and proactively we need to engage on a path of seeking ways in which we can get better at what we do and check always that these methods are what are required.

Therefore while this element is found within an Induction programme as a new starter in CAMHS, it is essential to consider this material as the foundation of a career long process.

Principles of continuous professional/personal development (CPD)

This module is intended to provide you with some thinking space to consider how you are going to adjust to your new role in CAMHS in your new setting. It is intended to begin your journey with an opportunity to think about what people, places and knowledge/language you will need to effectively and efficiently contribute to services for children and young people. Please remember your continuous development is just that; continuous. It happens over the course of your career and this is just one of the stages on your work travels. This means your development in CAMHS must be linked to your current practice/role/job and make a contribution to the quality of the service. In all instances your CPD activities should benefit children and young people who use services

You can think of CPD as planning an itinerary for a long worldwide trip. You will have stop of destinations along the duration of your career journey and you will need various knowledge and skills as you progress from destination to destination. You may need to learn slightly different 'languages' as you progress. All the while you will be building on you previous knowledge and adapting it to your new surroundings.

A journey

You may be a person who has a whole career trip already in your mind, or you may be a drifter, going from place to place as exploring what you find. In either case your journey has brought you to CAMH services as either the start or a stopping off point of your journey. How long you will stay will be up to you. In the first instance though you will need to makes some plans that will help you make the most of your stay.



This section will act as your friendly travel agent, offering suggestions to help you plan and benefit from your stay. Importantly we, as your agent, wish to see you contribute to the local community while you are there.

Start with an itinerary

Take a look at your Job Description, can you state the remit of your role in a couple of sentences?

Write a short description of your role in your notebook, then discuss with a trusted colleague or your learning mentor.

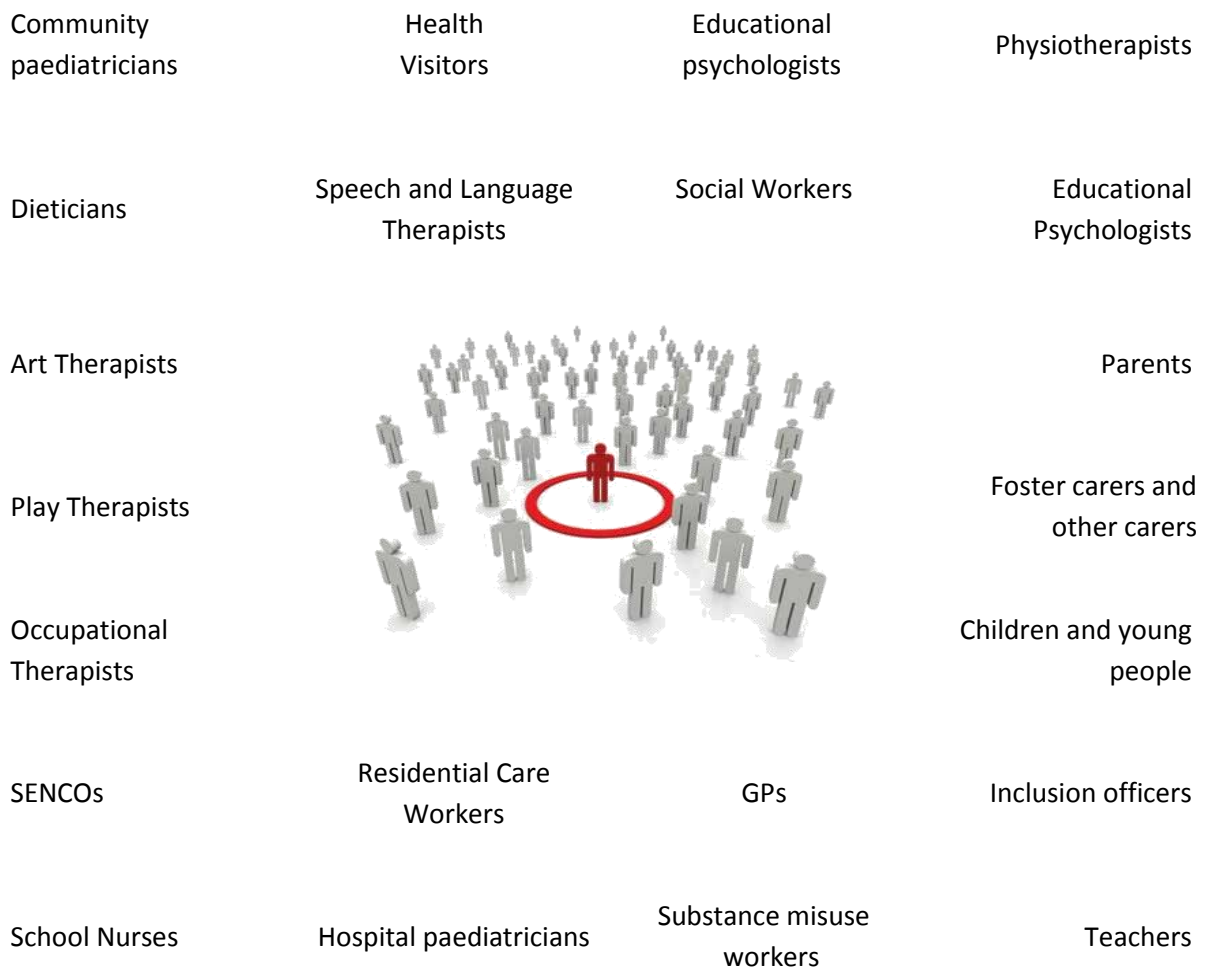
Now you have a short description of ‘where you are now’ and you may have an emerging idea on how you are to work in your new role.

In order to plan your career journey, think about what you have learned in this induction and what further development and learning you will need.

Meet the locals

Almost certainly, you will require the help of others in fulfilling your responsibilities. These are people who will help you settle in at work and will help you feel more confident and capable in your new role. They may help you with learning the new language and understanding the workings of how the system works. They may also help you discern how the system can be improved – remember, as someone new you see things with a fresh pair of eyes. You are able to help people in services reflect on their practice as much as they can help you understand how Children and Adolescent Mental Health Services work.

Have a look at the list below (you can add to it) and think about the people in services who can help you settle in at your new job.



Using the above diagram as a starting point, make a directory of local contacts using the proforma below, which is also available in the Resources section.

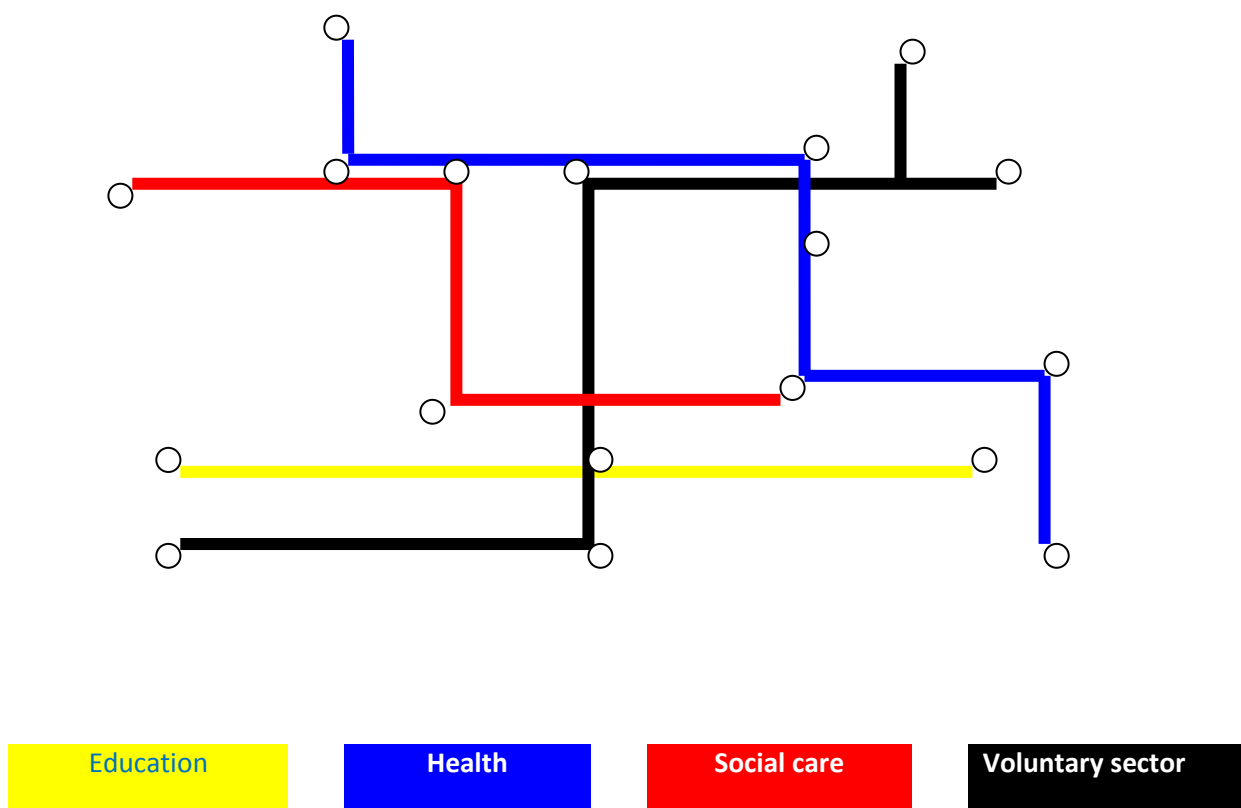
Build a local directory

Name	Role/job title	Contact information	Notes/reflections

In this new environment, there may be many fresh things to know and learn, such as new language skills and an awareness of the geography of services.

Use a map

Using the route map below, think about the services you need to work with in your new role. Do you know where they are, how you might get to them and what their relationship is with one another? An underground route map provides us with a way of understanding relationships and routes to places in a city. Use this one (and develop it further with new routes and new stations) to plan your journey through the services. The map is also available in the Resources section.



Learn some key words and phrases

Now you know where people and services are in the new territory and you know how to get there. It is important to reflect on coming to a greater understanding of how people communicate in this new environment. Consequently, developing a 'phrasebook' will be important in your new role. This will aid your communication and speed your socialisation to the new situation. We have made a start on a phrase-book with reference to some of the core knowledge you may need.

As you meet the professionals highlighted on page 3 above, you can enter their details in the directory of local contacts, place their organisations on the tube map, then start to learn their language and build your phrase book. The phrase book is also in the Resources section.

Phrasebook

CAMHS terms (add your own)	What do they call it?		
	Education	Social care	Service users
Clinical			
Clinician			
Conduct disorder			
Genogram			
Holistic			
Learning disability			
MDT			
Mental health			
On the spectrum			
Outcomes			
Reflective practice			
Therapy			
Tier 1			
Treatment			

Your continuing development as a worker for children and young people is critical to ongoing improvements in services. Over time services change, reflecting the changing needs of young people and their families and carers, so change is a normal part of service development. This affects the way we work, our role and functions and the knowledge we need to work effectively and efficiently. Paying close attention to our personal learning and development needs is part of everyday practice throughout a whole career and not just at induction points.

Time to evaluate the learning you have acquired during this induction. Complete the post induction profiling tool and enter the numbers into My Profile to see how much progress you have made.

Finally, use the training and development plan to inform your next appraisal.

We hope you have found CAMHS in Context useful and that you will continue to use it as a resource to support your work.

Self test 1a

Complete the following sentences, selecting the correct words from the box below.

During childhood a cognitive and [] map, or model, of self and other is developed through interactions and relationships.

This model shapes the way a child anticipates, predicts and [] to the world, based on their experiences.

Children who have experienced adversity such as physical, sexual or emotional abuse and neglect, or witnessing [] may be wary and distrustful of others.

Often parents and workers fail in their attempts to reassure children who are distressed because not enough attention is given to understanding their [] of events, which may be very different from adult reality.

Bad dreams and irrational fears can affect even the most [] and nurtured child.

Thinking and language require [] development of the brain, which occurs quite late in brain development. Once the cortex is developed it plays an increasingly important role in mediating experience.

From conception to early infancy simple [] movements develop and the infant has early affective experiences. During the first four years of life the [] of the brain quadruples, much of it in cortical growth.

In later childhood and adolescence the underdevelopment of [] networks in the pre-frontal cortex results in diminished ability for [] judgement, impulse control and goal-directed behaviour.

reflex

neuronal

affective

domestic violence

loved

weight

perception

relates

social

cortical

Self test 1b

Tick TRUE or FALSE for each of the following statements.

	TRUE	FALSE
Adolescents between the ages of 10 and 20 make up 20% of the total population of the UK.		
The proportion is considerably higher among black and minority ethnic (BME) communities, particularly those from Pakistani and Bengali groups.		
Mortality among adolescents fell significantly in the second half of the twentieth century.		
The main causes of death are accidents and self-harm.		
Ill health among teenagers is largely due to chronic disease and mental health problems.		
Patterns of health behaviour and service usage during adult life are not related to those in adolescence.		
Up to one in five adolescents may experience some form of psychological problem.		
Risk taking behaviour is strongly associated with mental health problems in adolescence.		
By adolescence the brain has stopped developing.		
Lesbian, gay, bi-sexual and trans-sexual young people are at greater risk of self-harm.		

Self Test 1c

Working Parents

	FACT	FICTION
Statutory Maternity Leave is for 52 weeks.		
You may be entitled to receive Statutory Maternity Pay for up to 39 weeks of the leave.		
Statutory Paternity Leave is additional to your normal holiday allowance.		
To qualify for Statutory Paternity Leave you must be an employee, having been with your employer for at least 26 weeks		

Single Parents

	FACT	FICTION
Lone fathers account for 1% - 8% of single parents		
Less than half of single parents have ever been married		
The average age for a lone parent is 26		
Single parents and their children are more likely to have a longstanding illness or disability, including depression or anxiety.		

Older Parents

	FACT	FICTION
There are now more first-time mothers in the 30-34 age group than in the 25-29 age group.		
There is an almost 100% increase from fifteen years ago in the number of women over forty who are now having babies		
The number of live births in England and Wales to mothers aged 40 plus was 12,103 in 1996		
The number of live births in England and Wales to mothers aged 40 plus was 23,706 in 2006.		

Younger Parents

	FACT	FICTION
The UK has the highest rate of teenage pregnancies in Western Europe.		
Young fathers are included in the statistics.		
The most important factor predicting young men's post-natal involvement was their childhood experiences		

Stepfamilies

	FACT	FICTION
Around a half of all divorces will occur within the first ten years of marriage.		
It is now probable that one in three children will experience their parents' divorce before they reach sixteen		
Currently in Britain there are over 2.5 million children in stepfamily life		

Self test 1d

For each item rate the person or organisation on the continuum of cultural competence with a star ✨

	DESTRUCTIVENESS	INCAPACITY	BLINDNESS	PRE-COMPETENCE	COMPETENCE	PROFICIENCY
Everyone who comes to me gets the same treatment, I don't care what colour they are.						
What do you expect from this kid: he lives on the Sink Estate.						
You have to get used to these demanding parents – Asians are more protective about their children.						
Of course she has an eating disorder, her father is a stockbroker and her mother is a socialite.						
Traveller children are hard to engage.						
The fact he is bi-sexual is irrelevant, I am treating his school phobia.						
I didn't know whether CBT would be acceptable to this young person, so I asked her.						
In supervision I continually question my ability to empathise with minority groups.						
My equalities training led me to offer a weekly session at the synagogue, so that is what I always do now.						
I supported young people in leading their own scrutiny group and have had it signed off by the Board.						
As a result of asking people what they want we are now offering outreach to community centres.						

Self test 2a

Tick TRUE or FALSE for each of the following statements:

	TRUE	FALSE
Support that acknowledges a young person's existing skills and strengths will equip them better to develop their own coping strategies		
The ability to deal with difficulty is given as a feature of positive mental health		
Educational failure is not associated with mental health problems in children		
Promoting good mental health is everyone's job		
Tertiary prevention could typically include perinatal and infant health programmes		
Prevention does not promote positive mental health		
Health promoting CAMHS is a holistic concept		
Being mentally well is not necessarily the same as always being happy		
Children with good mental health often have a difficulty in developing a sense of right and wrong		
Emotional health is about the way we think and feel, and the ability to cope with difficult things in life		

Here is an example of health prevention of poor sexual health; draw a connecting line from the statements below into the box for the correct level of prevention.

Screening for cervical cancer	Healthy lifestyle and treatment compliance for people diagnosed with HIV	Policy and public education promoting safe sex and positive choices in relationships
-------------------------------	--	--

PRIMARY	SECONDARY	TERTIARY


Complete the World Health Organisation's definition of mental health, by selecting the correct words from the box below and inserting them in the correct spaces.

A state of _____ in which the _____ realises his or her own _____, can cope with the normal stresses of life, can work _____ and _____, and is able to make a _____ to his or her own _____.

well-being community abilities
fruitfully individual contribution productively

Self test 2B

What sorts of information will be sought by each of the following practitioners for a multidisciplinary assessment and formulation? Complete the boxes.

<p>Family therapist (systemic perspective)</p>	<p>Clinical psychologist (psycho-social perspective)</p>	<p>Psychiatrist (biological perspective)</p>
<p>CAMHS social worker (social perspective)</p>	<p>Stefan  aged 12</p> <p><i>Referred: special needs school</i> <i>Disruptive behaviour</i> <i>Mood swings</i> <i>Cannot concentrate</i> <i>Frustrated and angry,</i> <i>Late to school, hungry</i> <i>Cared for by grandparents whose English is limited.</i></p>	<p>Mental health nurse (cognitive-behavioural perspective)</p>

Self test 2D. Join the interventions to the appropriate disorder. Three have been completed.

Draw a connecting line from this column to the correct place in the empty column

ANXIETY DISORDERS		Behaviour therapy; Interdisciplinary work Nutrition input; Parenting interventions; Prescribing, medical intervention
COPING WITH CHRONIC ILLNESS AND DISEASE		Behaviour therapy; Child development knowledge; Hypnosis
COPING WITH PAINFUL PROCEDURES		Behaviour therapy; Family therapy
DELIBERATE SELF HARM		PTSD knowledge/therapeutic skill; Trauma focused CBT
DEPRESSIVE DISORDERS		Family work; Group psychotherapy
DISORDERS OF CONDUCT		Prescribing, medical intervention
DISTURBANCES OF ATTENTION		Behaviour therapy; Cognitive behavioural therapy (CBT); Interdisciplinary work; Prescribing, medical intervention
EATING DISORDERS		Behaviour therapy; Prescribing, medical intervention
PERVASIVE DEVELOPMENTAL DISORDERS		Cognitive behavioural therapy (CBT); Nutrition advice
PHYSICAL SYMPTOMS NO KNOWN CAUSE		Cognitive behavioural therapy (CBT); Family therapy; Individual personal therapy (IPT); Prescribing, medical intervention
POST TRAUMATIC STRESS DISORDER		Family therapy; Multi Systemic Therapy (MST)
PSYCHOTIC DISORDERS		Behaviour therapy; Cognitive behavioural therapy (CBT); Psychoanalytic psychotherapy; Specialist nurse support; Systemic psychotherapy
SUBSTANCE MISUSE		Prescribing, medical intervention
TOURETTES SYNDROME		Interdisciplinary work; Multi systemic therapy (MST); Parenting interventions; Prescribing, medical intervention; Social work input

Self Test 4c

Complete Hart's Ladder




		Draw a connecting line from this column to the correct place in the left column
Youth-initiated, shared decisions with adults 8		Adults have the initial idea but children/young people are involved in every step of the planning and implementation. Their views are considered and they are involved in taking the decisions.
Youth-initiated and directed 7		Children/young people have the ideas, set up the project, and invite adults to join with them in making decisions.
Adult-initiated, shared decisions with youth 6		Adults decide on the project and children/young people volunteer for set roles within it. Adults inform them adequately and respect their views.
Consulted and informed 5		Children/young people have the initial idea and decide how the project is carried out. Adults are available but do not take charge.
Assigned but informed 4		Children/young people take part in an event, e.g. by singing, dancing or wearing T-shirts with logos on, but they do not really understand the issue or goal.
Tokenism 3		Adults lead children/young people in accordance with a scheme known only to the adults. The children/young people do not understand what is happening. They are not free to explore or act on their own thinking.
Decoration 2		Children/young people are asked to say what they think about an issue but have little or no choice about the way they express those views or the scope of the ideas they can express.
Manipulation 1		The project is designed and run by adults but children/young people are consulted. They have a full understanding of the process and their opinions are taken seriously.

Self test 4d

1. Explain the difference between multi agency and inter-agency.

 Multi agency means:	
 Inter-agency means:	

2. In the DCSF research on joint working, what were the main benefits for the following:

 Children and young people:	
 Professionals:	
 Service delivery:	



3. List the 7 key questions for information sharing by filling in the gaps below.

1. Is there a clear and _____ purpose for sharing information?
2. Does the information enable a _____ to be identified?
3. Is the information _____?
4. Do you have _____?
5. Is there sufficient _____?
6. Are you sharing _____ and _____?
7. Have you properly recorded _____?

4. Explain what Gillick competence refers to.

--

5. Give two benefits and two challenges for integrated services.

 Benefits	<ol style="list-style-type: none"> 1. 2.
 Challenges	<ol style="list-style-type: none"> 1. 2.

Solutions to Self Test 1a

During childhood a cognitive and affective map, or model, of self and other is developed through interactions and relationships.

This model shapes the way a child anticipates, predicts and relates to the world, based on their experiences.

Children who have experienced adversity such as physical, sexual or emotional abuse and neglect, or witnessing domestic violence may be wary and distrustful of others.

Often parents and workers fail in their attempts to reassure children who are distressed because not enough attention is given to understanding their perception of events, which may be very different from adult reality.

Bad dreams and irrational fears can affect even the most loved and nurtured child.

Thinking and language require cortical development of the brain, which occurs quite late in brain development. Once the cortex is developed it plays an increasingly important role in mediating experience.

From conception to early infancy simple reflex movements develop and the infant has early affective experiences. During the first four years of life the weight of the brain quadruples, much of it in cortical growth.

In later childhood and adolescence the underdevelopment of neuronal networks in the pre-frontal cortex tasks results in diminished ability for social judgement, impulse control and goal-directed behaviour.

Solutions to Self Test 1b

	TRUE	FALSE
Adolescents between the ages of 10 and 20 make up 20% of the total population of the UK		✓
The proportion is considerably higher among black and minority ethnic (BME) communities, particularly those from Pakistani and Bengali groups.	✓	
Mortality among adolescents fell significantly in the second half of the twentieth century.		✓
The main causes of death are accidents and self-harm.	✓	
Ill health among teenagers is largely due to chronic disease and mental health problems.	✓	
Patterns of health behaviour and service usage during adult life are not related to those in adolescence.		✓
Up to one in five adolescents may experience some form of psychological problem.	✓	
Risk taking behaviour is strongly associated with mental health problems in adolescence.	✓	
By adolescence the brain has stopped developing.		✓
Lesbian, gay, bi-sexual and trans-sexual young people are at greater risk of self-harm.	✓	

Solutions to Self Test 1c**Working Parents**

	FACT	FICTION
Statutory Maternity Leave is for 26 weeks.		⊗
You may be entitled to receive Statutory Maternity Pay for up to 39 weeks of the leave.	✓	
Statutory Paternity Leave is additional to your normal holiday allowance.	✓	
To qualify for Statutory Paternity Leave you must be an employee, having been with your employer for at least 26 weeks	✓	

Single Parents

	FACT	FICTION
Lone fathers account for 1% - 8% of single parents		⊗
Less than half of single parents have ever been married		⊗
The average age for a lone parent is 26		⊗
Single parents and their children are more likely to have a longstanding illness or disability, including depression or anxiety.	✓	

Older Parents

	FACT	FICTION
There are now more first-time mothers in the 30-34 age group than in the 25-29 age group.	✓	
There is an almost 100% increase from fifteen years ago in the number of women over forty who are now having babies		⊗
The number of live births in England and Wales to mothers aged 40 plus was 12,103 in 1996	✓	
The number of live births in England and Wales to mothers aged 40 plus was 23,706 in 2006.	✓	

Younger Parents

	FACT	FICTION
The UK has the highest rate of teenage pregnancies in Western Europe.	✓	
Young fathers are included in the statistics.		⊗
The most important factor predicting young men's post-natal involvement was their childhood experiences		⊗

Stepfamilies

	FACT	FICTION
Around a half of all divorces will occur within the first ten years of marriage.	✓	
It is now probable that one in three children will experience their parents' divorce before they reach sixteen		⊗
Currently in Britain there are over 2.5 million children in stepfamily life	✓	

Solutions to Self Test 1d

	DESTRUCTIVENESS	INCAPACITY	BLINDNESS	PRE-COMPETENCE	COMPETENCE	PROFICIENCY
Everyone who comes to me gets the same treatment, I don't care what colour they are.			✱			
What do you expect from this kid: he lives on the Sink Estate.		✱				
You have to get used to these demanding parents – Asians are more protective about their children.		✱				
Of course she has an eating disorder, her father is a stockbroker and her mother is a socialite.		✱				
Traveller children are hard to engage.		✱				
The fact he is bi-sexual is irrelevant, I am treating his school phobia.			✱			
I didn't know whether CBT would be acceptable to this young person, so I asked her.					✱	
In supervision I continually question my ability to empathise with minority groups.					✱	
My equalities training led me to offer a weekly session at the synagogue, so that is what I always do now.				✱		
I supported young people in leading their own scrutiny group and have had it signed off by the Board.						✱
As a result of asking people what they want we are now offering outreach to community centres.					✱	

Solutions to Self test 2a

	TRUE	FALSE
Support that acknowledges a young person's existing skills and strengths will equip them better to develop their own coping strategies	✓	
The ability to deal with difficulty is given as a feature of positive mental health	✓	
Educational failure is not associated with mental health problems in children		✓
Promoting good mental health is everyone's job	✓	
Tertiary prevention could typically include perinatal and infant health programmes		✓
Prevention does not promote positive mental health		✓
Health promoting CAMHS is a holistic concept	✓	
Being mentally well is not necessarily the same as always being happy	✓	
Children with good mental health often have a difficulty in developing a sense of right and wrong		✓
Emotional health is about the way we think and feel, and the ability to cope with difficult things in life	✓	


Here is an example of health prevention of poor sexual health

PRIMARY	SECONDARY	TERTIARY
Policy and public education promoting safe sex and positive choices in relationships	Screening for cervical cancer	Healthy lifestyle and treatment compliance for people diagnosed with HIV

The World Health Organisation's definition of mental health

A state of **well-being** in which the **individual** realises his or her own **abilities**, can cope with the normal stresses of life, can work **productively** and **fruitfully**, and is able to make a **contribution** to his or her **community**.

Solutions to Self test 2B

<p>Family therapist (systemic perspective)</p> <p>How does the family function, are there other family members within the system, what support networks are there and how do they work.</p> <p>How does the school system work, can Stefan function within it, how could it and/or Stefan adapt.</p>	<p>Clinical psychologist (psycho-social perspective)</p> <p>What is the source of Stefan's anger, is there a relationship with his cognitive ability/school achievements, what is frustrating him.</p> <p>Does he have satisfactory peer relationships, is there any evidence of bullying (of him or of others).</p>	<p>Psychiatrist (biological perspective)</p> <p>Does Stefan have any cognitive impairment/learning disability, is there a possibility of neuro-developmental disorder and/or a significant mental health problem/disorder.</p>
<p>CAMHS social worker (social perspective)</p> <p>What are the cultural factors for Stefan and his grandparents, do they belong to a wider cultural network, are they in need of translators/interpreters, are they isolated or excluded. What is the source of family income, does the age of the grandparents affect their ability to provide adequate food, clothing, etc. Where are Stefan's parents, are they involved, what is his legal status – might there be safeguarding issues.</p>	<p>Stefan  aged 12</p> <p><i>Referred: special needs school</i> <i>Disruptive behaviour</i> <i>Mood swings</i> <i>Cannot concentrate</i> <i>Frustrated and angry,</i> <i>Late to school, hungry</i> <i>Cared for by grandparents whose English is limited.</i></p>	<p>Mental health nurse (cognitive-behavioural perspective)</p> <p>How does Stefan think about himself, what are his core beliefs, how does he react in specific situations, what alternatives might there be for his thinking and behaviours.</p>



Solution to Self test 4C

Below is a fuller explanation of Roger Hart's Ladder, giving explanations of the levels of participation that each rung covers.




Hart's Ladder

Youth-initiated, shared decisions with adults 8	Children/young people have the ideas, set up the project, and invite adults to join with them in making decisions.
Youth-initiated and directed 7	Children/young people have the initial idea and decide how the project is carried out. Adults are available but do not take charge.
Adult-initiated, shared decisions with youth 6	Adults have the initial idea but children/young people are involved in every step of the planning and implementation. Their views are considered and they are involved in taking the decisions.
Consulted and informed 5	The project is designed and run by adults but children/young people are consulted. They have a full understanding of the process and their opinions are taken seriously.
Assigned but informed 4	Adults decide on the project and children/young people volunteer for set roles within it. Adults inform them adequately and respect their views.
Tokenism 3	Children/young people are asked to say what they think about an issue but have little or no choice about the way they express those views or the scope of the ideas they can express.
Decoration 2	Children/young people take part in an event, e.g. by singing, dancing or wearing T-shirts with logos on, but they do not really understand the issue or goal.
Manipulation 1	Adults lead children/young people in accordance with a scheme known only to the adults. The children/young people do not understand what is happening. They are not free to explore or act on their own thinking.

Solutions to Self Test 4d

 Multi agency means:	Many agencies
 Inter-agency means:	Agencies that are connected

In the DCSF research on joint working, the main benefits for the following:



 Children and young people:	Increased happiness and well-being, improvement in behaviour, better peer relationships, improved academic attainment
 Professionals:	Increased awareness and learning between health and education, education staff: increased access to mental health services and a greater understanding of the services available, health staff: greater understanding of the school context and impact on children's mental health.
 Service delivery:	Accessing children who would not normally be reached, identifying children's problems early, services more accessible to parents and children, less stigmatising, more appropriate referrals

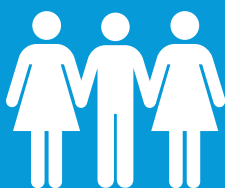
7 key questions for information sharing

1. Is there a clear and **legitimate** purpose for sharing information?
2. Does the information enable a **living person** to be identified?
3. Is the information **confidential**?
4. Do you have **consent**?
5. Is there sufficient **public interest**?
6. Are you sharing **appropriately** and **securely**?
7. Have you properly recorded **your decision**?

Gillick competence refers to a term originating in England, which is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Two benefits and two challenges for integrated services.

 Benefits	<ol style="list-style-type: none"> 1. Members are still linked in to what is going on in their home agency 2. Members likely to have access to training and personal development in their home agency
 Challenges	<ol style="list-style-type: none"> 1. Developing a sense of joint purpose so that practitioners identify more with the new service than their role in their home agency 2. Managing any issues around pay and conditions for staff doing joint work at different levels of pay



For information please contact:

Barry Nixon
NCSS National Workforce Lead
barry.nixon@5bp.nhs.uk

Published: October 2010

Copyright © 2010 Skills for Health.
All rights reserved.



E-mail: office@skillsforhealth.org.uk