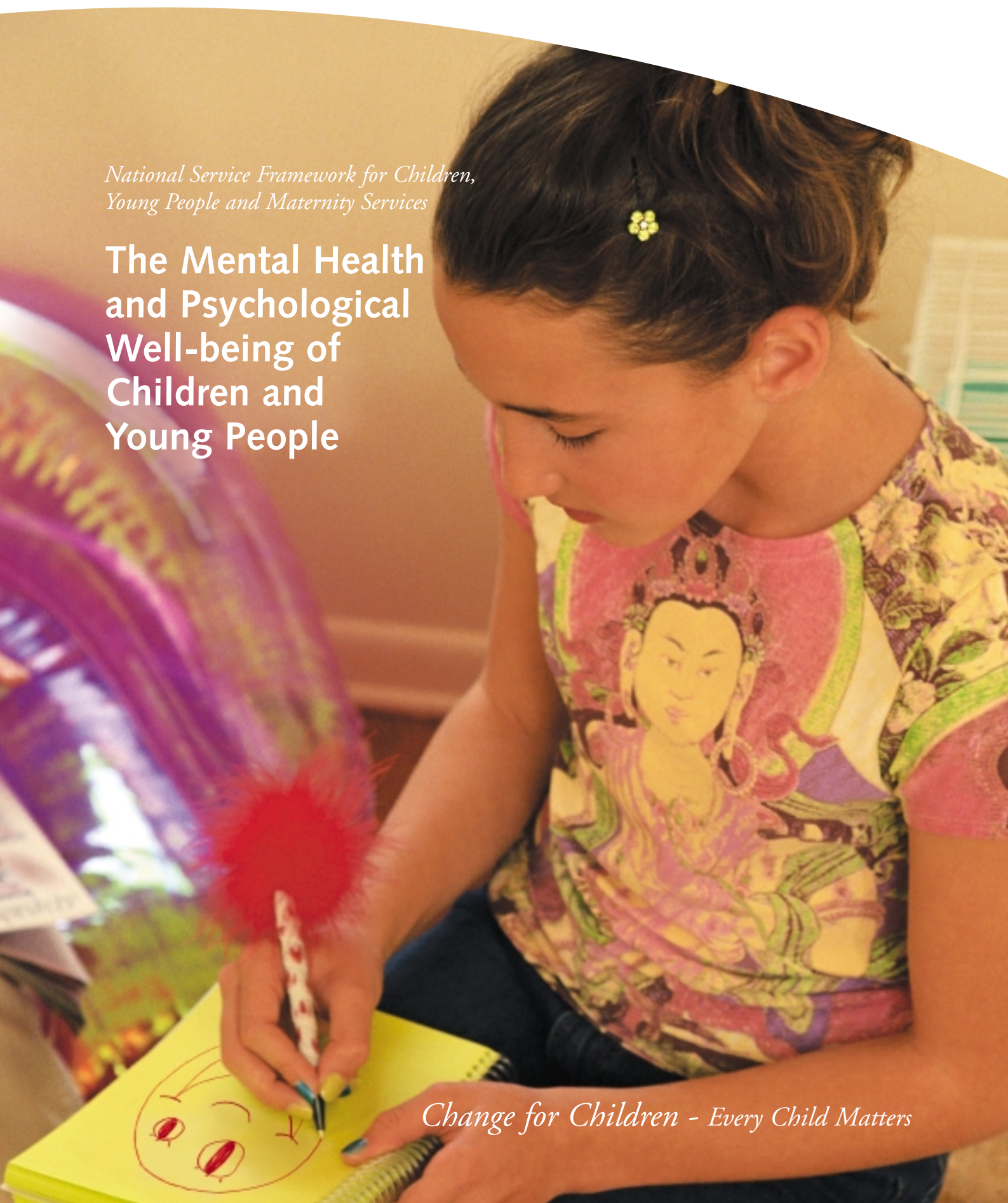


*National Service Framework for Children,  
Young People and Maternity Services*

# The Mental Health and Psychological Well-being of Children and Young People

*Change for Children - Every Child Matters*



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# Contents

## Standard 9

### The Mental Health and Psychological Well-being of Children and Young People

1. Introduction	3
2. Rationale	6
3. Early Years	9
4. Mental Health Promotion and Early Intervention	10
5. Partnerships with Children, Young People and their Families	13
6. Access and Location of Services	15
7. Improving Service Equity	20
8. Partnership Working	25
9. Developing High Quality Multi-disciplinary CAMHS Teams	28
10. Planning and Commissioning Services	38
11. Training and Development	41
<b>Appendix 1:</b> A Note on Terminology	44
<b>Appendix 2:</b> A Comprehensive CAMHS	48



# Standard 9: The Mental Health and Psychological Well-being of Children and Young People

## 1. Introduction

1.1 The National Service Framework for Children, Young People and Maternity Services establishes clear standards for promoting the health and well-being of children and young people and for providing high quality services which meet their needs.

1.2 There are eleven standards of which this is the ninth. They cover the following areas:

**Standard 1** Promoting Health and Well-being, Identifying Needs and Intervening Early

**Standard 2** Supporting Parenting

**Standard 3** Child, Young Person and Family-centred Services

**Standard 4** Growing Up into Adulthood

**Standard 5** Safeguarding and Promoting the Welfare of Children and Young People

**Standard 6** Children and Young People who are Ill

**Standard 7** Children and Young People in Hospital

**Standard 8** Disabled Children and Young People and those with Complex Health Needs

**Standard 9** **The Mental Health and Psychological Well-being of Children and Young People**

**Standard 10** Medicines for Children and Young People

**Standard 11** Maternity Services

1.3 This Standard addresses the mental health needs of children and young people and should be read in conjunction with Standards 1-5. Standards 1, 2 and 4 describe further mental health promotion interventions for children, young people and their families. Standards 6 and 7 describe the additional mental health needs of children and young people who are ill or who are in hospital. All professionals caring for children and young people who require medicines should also address the issues covered in Standard 10. 'Primary care' is used in this Standard to describe all first line services who have contact with children and their families. A further description of the language and terms used in this Standard can be found in Appendix 1.

### **Vision**

#### **We want to see:**

- > An improvement in the mental health of all children and young people.
- > That multi-agency services, working in partnership, promote the mental health of all children and young people, provide early intervention and also meet the needs of children and young people with established or complex problems.
- > That all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.

### **Standard:**

**All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.**

### Markers of Good Practice

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. Child 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.
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 multi-agency approach. Contingency arrangements are agreed at senior officer levels between health, social services and education to meet the needs and manage the risks associated with this particular group.
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 continuity of care is ensured by use of the 'care programme approach'.

## **2. Rationale**

- 2.1** 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.
- 2.2** Ten per cent of five to fifteen year olds have a diagnosable mental health disorder. This suggests that around 1.1 million children and young people under eighteen would benefit from specialist services. There are up to 45,000 young people with a severe mental health disorder. Around forty per cent of children with a mental health disorder are not currently receiving any specialist service.
- 2.3** Similar numbers of children and young people with less serious mental health problems will need some help. In most cases, this will be provided by services in primary health care, social care, education (including early years) and the voluntary sector.
- 2.4** In a minority of cases, the nature and severity of the mental disorder may lead to a period of in-patient care. For some of these, where there is a significant risk of harm to the child or to others it may also be necessary to provide treatment under the Mental Health Act 1983. There are some circumstances in which parents and practitioners, faced with difficult treatment decisions, are reassured by the clear legal authority provided by the Act, which also provides safeguards for the child's rights. Under the Government's reform of the legislation, it is proposed to introduce new and improved safeguards for children and young people.
- 2.5** 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.



- 2.6 It is important to recognise that supporting children and young people with mental health problems is not just the responsibility of specialist CAMHS. In many cases, the intervention that makes a difference will come from another service. For example, a child presenting with behavioural problems may make better progress if his/her literacy problems are also addressed, in which case an input is required from education. The lack of provision in one service may impact on the ability of other services to be effective. Partnership working is an essential requirement of high quality service provision.
- 2.7 Some children in special circumstances have greater needs regarding their mental health. Looked after children are five times more likely than their peers to have a mental health disorder. Children and young people with significant learning disabilities are three to four times more likely to have a mental disorder and at least forty per cent of young offenders have been found to have a diagnosable mental health disorder.
- 2.8 *Improvement, Expansion and Reform*<sup>1</sup>, which set out the Priorities for the 2003-06 planning round, set the expectation that comprehensive mental health services for children and young people would be available in all areas by 2006 (the requirements for a 'Comprehensive CAMHS' are outlined in Appendix 2). This should include early intervention and mental health promotion. It also states that CAMHS is to be increased by at least 10% each year across the service according to agreed local priorities (demonstrated by increased staffing, patient contacts and/or investment).
- 2.9 *National Standards, Local Action*<sup>2</sup>, which sets out the priorities for 2005/06-2007/08 for the NHS, emphasises the need to improve outcomes for individuals and maintain the levels of service achieved through the 2003-06 planning round. Performance against existing commitments which extend beyond April 2005 will feed into the Healthcare Commission's performance rating of NHS bodies, including NHS Foundation Trusts.

- 2.10 This standard highlights the need to improve service provision at all levels from universal services, promoting mental health and providing early interventions, to highly specialised services. The familiar terminology of four tiers of provision that has guided the commissioning and planning of services over recent years still stands; this is outlined in Box 1 and described in detail in Appendix 1.

### Box 1: The Four Tier CAMHS Framework

Tier 1: A primary level of care.

Tier 2: A service provided by specialist individual professionals relating to workers in primary care.

Tier 3: A specialised multi-disciplinary service for more severe, complex or persistent disorders.

Tier 4: Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units.

- 2.11 Services for children and young people should be provided irrespective of their gender, race, religion, ability, culture or sexuality. This standard emphasises the importance of improving access to CAMHS to ensure greater equity is achieved. These developments can only occur if specialised CAMHS provision is strengthened in terms of capacity and skills and through planned commissioning processes which are undertaken in partnership with service providers.



## Interventions

### 3. Early Years

- 3.1 Lack of appropriate stimulation in the early years may result in language delay and together with inappropriate child-rearing practices, especially if characterised by neglect or inconsistency, may lead to emotional or behavioural disorders. Appropriate parenting styles are fundamental to caring for children's mental health. Early attachment and bonding between parents and their babies is important and needs to be supported. Particular support may be required for parents who are ill (including those with mental illness) or who have a disability and this necessitates CAMHS working closely with primary care services, services for adults and early years support services such as Sure Start (*see Standard 2 for interventions to support parenting*). Dedicated expertise in Tier 2 and 3 services, supporting the work of a range of community professionals, will enable services to respond urgently to vulnerable parents and their infants.
- 3.2 To address the needs of those parents or carers and their young children whose problems are more serious and complex than can be dealt with by primary care and universal services, support, consultation and ready access to therapeutic services needs to be available from specialist CAMHS. *See Standards 1 and 2*

Primary Care Trusts and Local Authorities ensure that CAMH Tier 2 and 3 services with specialist expertise, are available to provide assessment and therapeutic support for infants/young children and their families to promote parent child relationships and address attachment difficulties.

CAMH Tier 2 and 3 services with specialist expertise work together with those local community services, especially early years services, which work with infants/young children and their families, to promote parent child relationships and address attachment difficulties and early problems.

#### 4. **Mental Health Promotion and Early Intervention**

- 4.1 All children and young people and their parents or carers require access to information and supportive environments to ensure that the child or young person's mental health is promoted. Specific activities such as tackling bullying, the provision of education to increase awareness of mental health issues and to improve the recognition of children's emerging needs, and the provision of support for those children with particular needs, have a vital role to play in improving the chances for children and young people. Everyone in a community has a role to play in ensuring that the environment in which children are growing up promotes their mental health.
- 4.2 There are some children and young people, such as those in special circumstances or those with learning difficulties and/or disabilities, who will be at greater risk of developing mental health problems. For these children and their parents or carers, the provision of early intervention may make a significant difference.  
*See Standards 1, 2 and 4*



All staff who work with children and young people, in any service, are able to recognise the contribution they can make to children's emotional well-being and social development and use their own professional skills in supporting children when there is concern about their well-being. They understand their responsibilities for supporting children in difficulty.

Staff who work directly with children are able to access support and advice from specialist CAMHS. In addition to specialist CAMHS, there are a range of staff from children's services who can work in collaboration with front line staff to aid early identification and support of children with mental health difficulties. These include social workers, behaviour specialists, educational psychologists and specialist support staff.

Primary Care Trusts and Local Authorities ensure that local protocols for referral and support are agreed between relevant agencies.

Primary Care Trusts and Local Authorities ensure that local needs assessments identify children in special circumstances (including those who are homeless, those who misuse substances, asylum seekers, young people in young offenders institutions and looked after children) and that services are in place to meet their needs.

*See Standard 1*

Services ensure that an emphasis is placed on children and young people who are vulnerable to mental health problems and on providing focussed, structured, proactive programmes which target risk factors, using the common assessment framework as appropriate. *See Standard 3*

### **CAMH Workers for Primary Care**

- 4.3** CAMH Workers for Primary Care are a key resource for work in the interface between specialist CAMHS and Tier 1, to support staff in primary health care, education, social services and other agencies. The National Committee for Primary Mental Health Workers in CAMHS has prepared a description of the role of the CAMHS Primary Mental Health Worker<sup>3</sup>. Whilst there are core components of the skills and knowledge base and role that are universal, each area will also need to develop the detail of these posts with their own local needs in mind.
- 4.4** CAMHS workers in primary care settings should be offered high levels of supervision and support to ensure that they do not become isolated.

Primary Care Trusts and Local Authorities continue to develop early intervention and prevention CAMHS within their areas through the provision of CAMH workers in community settings.

Primary Care Trusts and Local Authorities ensure that CAMH workers for primary care work in partnership with specialist CAMHS and that their training, supervision and support needs are addressed.

## 5. Partnerships with Children, Young People and their Families

5.1 It has been challenging for CAMHS to ensure the participation of children and young people and their families at all levels of service provision. It is clear that a variety of creative approaches are needed to improve participation and user involvement. Ways in which children and young people can participate can be found in *Building a Culture of Participation*<sup>4</sup>.

*See Standards 3 and 4*

The views of service users are systematically sought and incorporated into reviews of service provision.

Service providers and commissioners develop proposals for user involvement, ranging from consultation to participation of children and young people and their parents or carers. The DfES-funded Healthy Care Programme<sup>5</sup> ([www.ncb.org.uk](http://www.ncb.org.uk)) provides guidance on the effective participation of looked-after children.

Clinical audit includes user's views in relation to individual outcomes and service provision.

### Enhancing Partnerships with Black and Minority Ethnic Groups

5.2 The mental health needs of minority communities are currently not being specifically met within many mainstream services, although there are aspirations to do so. There are, however, good examples of services that have been created to engage and address their needs<sup>6</sup>.

5.3 Concepts of mental illness and the understanding of the origins of children's emotional and behavioural difficulties vary across cultures. Services need to be sensitive to these differences and ensure that staff are equipped with the knowledge to work effectively with the different groups represented within the community they serve.

- 5.4 The experiences of those families who are refugees or are seeking asylum, particularly those from war torn countries, have often been highly traumatic. The provision of effective mental health care can be extremely challenging, especially if there are language barriers. For localities with a significant population of such families, specific arrangements may need to be made to provide appropriate mental health care for the children and young people within these families.<sup>7</sup>

The needs of specific black and minority ethnic groups within each community are represented in the local CAMHS needs assessment.

Primary Care Trusts and Local Authorities ensure that local directories of services for minority groups are available, to enable these children, young people and their families to receive appropriate support.

All staff working within CAMHS are sensitive to the particular needs of children and young people from different black and minority ethnic groups.

Training is available for staff to work effectively with families from specific black and minority ethnic groups within their community.

Services aim to recruit and train professionals from the ethnic minorities for whom services are being provided, and review the provision and training of interpreters to ensure that best practice is achieved.



## 6. Access and Location of Services

*“We want a choice where we get help, for instance in school and outside school in a place that isn’t medical.”*

(A user of child and adolescent mental health services)

- 6.1 Children and young people and their carers want to be able to access services easily. The location should be easy to get to and well-publicised. The views of children, young people and their parents will vary regarding the most appropriate location for receiving help. Services need to be sensitive to these differing views and aim to provide access in a variety of settings, some of which provide the opportunity for self-referral.
- 6.2 Many children, young people and their families who could benefit from mental health services for assessment and treatment are not accessing services. There are a variety of reasons for this: a lack of trust in statutory services; a wish to solve problems themselves; a lack of recognition and agreement that a problem exists; a fear of being teased and stigmatised; a fear of confidentiality being broken and a belief that nothing can be done. These can all affect the take-up of help.
- 6.3 It is often the children and young people about whom there is most concern, and who are likely to experience the poorest outcomes, who are most reluctant to seek help. Services therefore need to respond flexibly and creatively in order to be able to meet their needs. The setting in which the first contact is made may make a difference e.g in school which may be seen as less stigmatising for some or, where confidentiality is of particular concern, away from school for a young person who fears being teased.
- 6.4 For some children and young people and their families, initial access may best be provided in a location of their choice (e.g. school, general practice, or home) with the appropriate facilities. Failure to attend clinic-based appointments should not be seen as a lack of motivation or act as a trigger to close a case but as an indication of the need to review the nature of the service offered.

- 6.5 It may take some time before a young person is able to take advantage of more specific therapeutic approaches, e.g. cognitive behavioural therapy, so the process of 'engagement' and establishing a trusting therapeutic relationship can be a necessary prelude to a treatment intervention and may take some time. Successful outcomes for children and young people with complex mental health problems rely to a great extent on them being able to understand and 'own' their problems. A flexible approach to the engagement of young people in their own mental health care is often necessary and the relationship with their mental health worker is crucial. *See Standard 3*

Primary Care Trusts and Local Authorities ensure that information is provided in each locality which explains how to seek advice and gain access to specialist services as necessary.

Services are offered as near to home as possible and in a number of settings to take account of the different needs and choices of children, young people and their parents or carers. They should include locations such as schools, homes and family centres, which may be perceived as less stigmatising, as well as traditional clinic settings.

Primary Care Trusts and Local Authorities address the need to take services closer to children and young people (e.g. by providing school-based and family/health-centre based services), especially where parental co-operation presents difficulties, and consider the need for self-referral through a number of entry points to CAMHS at Tiers 1 and 2. *See Standard 1 and 3*

Services need to establish flexible arrangements in order to meet the needs of children, young people and their families who are reluctant to seek help.

Services ensure that training and supervision is in place to address strategies for engagement and to ensure the high quality relationship necessary for successful intervention.

## Access to Specialist CAMHS

- 6.6 Waiting too long for a service is clearly unhelpful. The parent, child or young person may be less willing to take up a service where the wait has been excessive. Similarly, there is a risk that a condition may deteriorate and become more difficult to treat.
- 6.7 There is strong evidence that poor attendance rates in CAMHS are most closely associated with longer waiting lists and with whether parents understand and agree with referral.

*“I didn’t have to wait very long to get a place. I don’t think that people should have to wait more than a few weeks because the problems can get worse if they are left. About one month should be the maximum wait.”*

*(A user of child and adolescent mental health services)*

Services agree referral criteria that are explicit and are negotiated between commissioners and providers.

Initiatives including increasing capacity and/or alternative care pathways (e.g. the involvement of a voluntary agency or other specialist community resource) are in place to address the gaps in service provision.

Mechanisms for increasing access take into account treatment needs, and do not compromise the overall quality of services provided.



### **Emergencies and Out of Hours Services**

- 6.8** Children and young people presenting as emergencies or as requiring urgent assessment and intervention include: those who have rapidly developed a serious or life-threatening condition, for example, a young person who is psychotic or suicidal; those whose needs have become urgent as a consequence of the more routine services having been unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support. Improving the scope of existing services and designing them to reflect the opinions of children, young people and their families may do much to reduce unpredicted out-of-hours demands.
- 6.9** Children and young people with urgent mental health needs may present to a range of agencies during out-of-office hours. These include emergency duty social workers, police, general practitioners and other primary health care professionals and community workers. Professionals working in these agencies need to be able to make an initial assessment of the child or young person's needs and be able to make appropriate referral to specialist services if required.
- 6.10** Specialist advice is required when a child or young person is presenting with acute psychiatric illness. Currently, on-call and 24-hour specialist CAMHS are not able to be provided in many areas. The lack of equity of access to an emergency out-of-hours service from CAMHS needs to be addressed through short term and long term planning. In the short term, a variety of approaches may be taken to ensure adequate cover in these circumstances. These include: arrangements with adult mental health services to provide first on-call; specialist registrars from a rotation to provide specialist CAMHS on-call, across several providers; consultant child and adolescent psychiatrists having collaborative arrangements with neighbouring services; and multi-disciplinary on-call arrangements, with psychiatric back-up.
- 6.11** In the longer term, an expanded capacity within CAMHS will lead to an improved ability to respond to urgent need.

*See Standard 6*

Primary Care Trusts and Local Authorities ensure that policies and protocols for the management of children and young people with emergency mental health needs are developed in partnership and clarify the level of service provided and the criteria for referral.

Arrangements are in place to ensure that 24 hour cover is provided to meet children's urgent needs and a specialist mental health assessment is undertaken within 24 hours or during the next working day where indicated. (This clarifies the distinction between the initial urgent assessment, for which a range of services, including accident and emergency services are responsible, and the specialist mental health assessment, for which CAMHS are responsible).

All staff who are likely to be called upon to carry out the initial social and mental health assessment receive specific training.

### **Emergency Admission to Tier 4 Services**

**6.12** A small number of children and young people require emergency admission to in-patient care. When circumstances permit, prior consultation with the referrer around the emergency may allow the admission to take place as a planned event or alternative arrangements to be made. The latter will be dependent on the level of service provision.

Primary Care Trusts and Local Authorities ensure there is local provision of a range of services (i.e. assertive outreach, domiciliary, community and day services) so that children and young people are not inappropriately admitted to in-patient units.

Where a child or young person needs to be placed in an in-patient unit, every effort is made to find a place that is close to home, so that contact with the family can be maintained.

Services ensure that admission procedures and policies for all in-patient settings are explicit and developed in partnership with relevant agencies.

Children and young people are admitted to settings which are appropriate for their age and maturity. *See sections 9.7 to 9.12*

## 7. Improving Service Equity

- 7.1 While there are many groups of children and young people who require a range of specialised services, there are particular groups whose needs have not been met well by recent service provision. Young people aged sixteen and seventeen years and children with both a learning disability or pervasive developmental disorder and mental health problems have not received sufficient input from CAMHS.
- 7.2 Local needs assessment may identify other groups of children and young people for whom service development is required e.g. looked after children, where there has been recent significant improvement in provision, children with conduct disorder or severe behavioural problems, children and young people who are homeless, young people in young offenders institutions and asylum seeking children, where expertise is not readily available.

Primary Care Trusts and Local Authorities ensure that both the commissioning and delivery of services are informed by a multiagency assessment of need that is updated on a regular basis. *See section 10 Planning and Commissioning*



## **Services for Young People of Sixteen and Seventeen Years of Age**

- 7.3** Traditionally, CAMHS have been resourced for young people up to sixteen years of age or up to school-leaving age, although about half now offer services up to the eighteenth birthday. There is a broadly held view and concern that many young people of sixteen and seventeen years of age are not receiving the services they require since they fall into the gap between child and adult services, the latter tending to have a lower age threshold for their services of eighteen years.
- 7.4** There is normally a wide variation in the age when young people achieve maturity and independence, especially for those with learning disability and other impairments. For the majority of sixteen and seventeen year olds for whom admission becomes necessary, admission to a young people's unit is the appropriate and preferred option. However, for some young people who are living away from the family home or those with certain types of clinical need, an adult facility may be more appropriate. A degree of flexibility is clearly required to ensure that young people receive treatment in an environment that promotes their engagement and responds to their developmental needs. This will mean that some young people may wish to exercise choice about which service feels most appropriate for them.
- 7.5** The impact of extending the age range for CAMHS at local level will need to take account of the resources required to meet the increasing incidence of severe mental illness in late adolescence and the inevitable refocusing of services that will be necessary to meet their needs. This will include ensuring that there is a strong focus on vocational and social issues in order to ease young people's transition into adulthood and reduce the likelihood of social exclusion, so often a secondary consequence of mental illness.<sup>8</sup>

*See Standard 4*

Primary Care Trusts and Local Authorities develop a long term strategy to ensure that young people under eighteen years of age are provided with services which meet their developmental needs. This will require planning: to address the increase in the capacity of the workforce; training; and developing the infrastructure.

Primary Care Trusts and Local Authorities ensure that local agreements are in place for handling referrals of young people to ensure that there are no gaps in service provision and to allow some degree of choice and flexibility.

Services ensure that young people experience a smooth transition of care between child and adult services and protocols are in place to ensure a flexible and organised approach is taken and that a developmental perspective is incorporated into staff training.  
*See Standard 4*

Services ensure that attention is paid to the child protection needs (in line with ACPC policies) (*see Standard 5*) and the dignity and safety of young people cared for in adult psychiatric beds.

Primary Care Trusts and services are involved in the collaboration between CAMHS and adult mental health services to develop early intervention teams for young people with early onset psychosis.

The Care Programme Approach is used on discharge from in-patient care and on transition from child to adult services.



## Services for Children with Learning Disabilities

- 7.6 One third of NHS specialist CAMHS provide specific services to children and adolescents with learning disabilities. Services are also provided from within life-span learning disability services and in child health services. Many paediatricians have considerable expertise and experience in this field. Nevertheless, it is inappropriate that they should be expected to cover the broad range of mental health difficulties for those with learning disabilities. Given that some forty per cent of children with learning disabilities have a diagnosable mental disorder and this rate is even higher in those with severe learning disabilities, the low level of resources available to the children and their families represents serious inequity and a significant challenge for the development of appropriate services.
- 7.7 There is a need to ensure that children and young people with learning disability who require psychiatric care have access to appropriate services which meet their needs and that they are not disadvantaged because of their disability.
- 7.8 The development of services for children with learning disabilities will require a workforce with the competencies and knowledge of working with children and young people with complex, severe and multiple disabilities (especially those with moderate or severe learning disabilities) and their families. Co-ordination of learning disability CAMHS with other services should be achieved through partnerships which preserve and enhance the quality and effectiveness of specialist provision already in place. *See Standard 8*

Primary Care Trusts and Local Authorities ensure that children and young people with learning disabilities receive equal access to mental health services at all Tiers (1-4) of CAMHS. This includes:

- > Mental health promotion and early intervention (including attention to attachment and parenting issues);
- > Training and support to front-line professionals, in particular in the recognition of normal development and developmental delay;
- > Adequately resourced Tiers 2 and 3 learning disability specialist CAMHS with staff with the necessary competencies to address mental health difficulties in children and young people with learning disabilities or pervasive developmental disorders. Currently, there is a shortfall of staff with the specific competencies to work with learning disabled children with mental health difficulties. This requirement for training will need to be addressed through initiatives such as the sharing of expertise by continuing professional development (CPD), consultation and supervision and the development of clinical networks, and
- > Access to Tier 4 services providing in-patient, day-patient and outreach units for children and adolescents with learning disabilities and severe and complex neuro-psychiatric symptomatology.

Commissioners ensure that joint agency planning and commissioning takes place between health, social services, education and voluntary service organisations at a local level, for those children and adolescents with learning disabilities who have severe, complex and enduring needs, and those with difficult to manage behaviour.

Partnership working at local level between service providers ensures that a co-ordinated and integrated package of care is available for children and young people.

## 8. Partnership Working

- 8.1 *Every Child Matters*<sup>9</sup> highlights the Government's commitment to improving partnerships between all agencies. The complexity and variety of children's service provision in any one locality also creates a logistical challenge for services attempting to achieve good partnerships. This needs to be taken into account in the planning and commissioning of services. *Removing Barriers to Achievement: The Government's Strategy for SEN*<sup>10</sup> also highlights the importance of partnership working to improve outcomes for children and young people with special educational needs.
- 8.2 Partnership working across agencies working with children and young people with mental health problems can be a challenging task. The lack of understanding of the respective roles, duties, responsibilities and organisation of the different agencies and professionals and of their different language, may lead to poor communication, misunderstandings and frustration. Effective partnership working can improve children and young people's experience of services and lead to improved outcomes. There is a continuing role for universal services once a child or young person has been referred to specialist CAMHS, and ensuring that partnership working is effective is particularly important in these situations.



- 8.3 Factors that can facilitate joint working between CAMHS and schools have been identified<sup>11</sup> are outlined in Box 2.

**Box 2: Factors that facilitate joint working between CAMHS and schools**

- > Secondments between organisations;
- > Being based in the same location;
- > Flexibility of recruitment so that people move between posts across organisations;
- > Having a clear understanding of the different roles and expertise of members of staff;
- > Having a clear rationale for working jointly, which is shared with the team;
- > A commitment to joint working from all levels of the service; and
- > Informal meetings, networking and team building.

Commissioners and services are able to demonstrate multi-agency partnership working in the following areas:

- > The provision of services to children and young people who may or may not have been harmed, as set out in *Working Together to Safeguard Children*<sup>12</sup>: contributing to the assessment of complex child abuse cases; the assessment and provision of post-abuse therapeutic services; and services for looked after and adopted children (see *Standard 5*);
- > The delivery of services to children and young people with significant behavioural difficulties ('conduct disorder'), who are at risk of exclusion from school; based on agreed protocols;
- > The delivery of services to young people with mental health disorders who are misusing drugs and alcohol;
- > Agreements between health, education and social services, and youth justice, which may need to be organised across several Primary Care Trusts/Local Authorities, for the joint funding, assessment and provision of services (including specialist residential provision when required), for children and young people with complex, severe and persistent behavioural and mental health needs. Contingency arrangements are agreed at senior officer levels between health, social services and education to meet the needs and manage the risks associated with this particular group;

- > The assessment of educational needs and provision of services for children and young people with mental health problems, including those with special educational needs and/or learning disabilities and looked after children, whether they are living in the community, in hospital or residential settings. For example, children and young people with serious mental health disorders require their ongoing education to be provided, either in home tuition units, or in hospital;
- > Specialist CAMHS input where there are locally agreed joint initiatives such as Behaviour and Educational Support Teams (BESTs), pupil referral units and provision for children with Behavioural, Emotional and Social Difficulties (BESD);
- > Appropriate, negotiated, resourced and integrated CAMHS contribution to youth justice services;
- > Protocols between CAMHS and adult mental health services to ensure collaborative working arrangements and joint provision, where appropriate;
- > Arrangements for joint training and provision for the identification, assessment and therapeutic services, where appropriate, of children of mentally ill and drug and alcohol dependent parents and those in families subject to domestic violence (*see Standard 5*);
- > The development of Early Intervention teams for young people with a first-episode psychosis that effectively integrate child, adolescent and adult mental health services through joint commissioning and collaborative working arrangements, and
- > Collaborative arrangements with paediatric units and wards for the joint care of children, where appropriate, protocols for the management of deliberate self-harm and the availability of paediatric liaison by CAMHS professionals.

See *Standard 7* sections 4.25 to 4.27

Face-to-face working and joint training is provided to overcome the barriers to co-operative working relationships.

## 9. Developing High Quality Multi-disciplinary CAMHS Teams

### Developing Tier 3 Services

- 9.1 A critical mass of staffing is required for services to be safe, timely and effective and able to respond to a wide range of demands which include the provision of: specialist and multi-disciplinary assessment and treatment services; teaching, specialist consultation and liaison services; research and audit; and support, training, consultation and face-to-face work within primary care settings. The precise level of staffing will vary according to indices of deprivation, whether the service is in a rural or urban setting, the number of local partnerships required and teaching responsibilities. As services take on the new responsibilities determined by this National Service Framework, additional staffing will be required locally. Where services have good core resources, they are also able to offer a range of specialist and community out-reach services; this arises from the availability of a critical mass of staffing.
- 9.2 Estimating the numbers of staff required to populate viable multidisciplinary teams and services at Tier 3, that can meet all the demands and provide a sustainable service, is not straightforward. Much depends upon the local demography and the range and types of service needed and offered. Nonetheless guidance has frequently been requested. An analysis of a number of attempts to estimate staffing need has suggested the following: a generic specialist multidisciplinary CAMHS at Tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of 20 whole time equivalents (WTEs) per 100,000 total population, and a non-teaching service, a minimum of 15 WTEs. Care should be taken to ensure that the number of new cases and overall caseload of each professional is compatible with the complexity of care provided and the specific interventions employed.

- 9.3 It should be noted that these figures do not reflect demographic variations and areas with high levels of deprivation will need higher staffing levels. While the figures do allow for consultation to other agencies, they do not allow for dedicated staff time from Tier 3 to services such as Sure Start, looked after children teams, special educational needs (SEN) provision, BESTs, youth offending teams etc. Nor would they necessarily be sufficient to provide a team dedicated to specific conditions or specialist services like a day unit. Specific services such as these are increasingly required to meet the expectations now placed on a modern CAMHS.
- 9.4 Unrealistically high levels of new case assessment in an under-resourced service not only preclude effective work, but may create an unsafe service through insufficient intervention, or a lack of effective monitoring. Excessive caseloads can also squeeze essential workforce activities such as teaching, training and consultation.
- 9.5 People with the necessary skills and competencies to deliver a comprehensive CAMHS include child psychiatrists, clinical child psychologists, CAMHS trained nurses, occupational therapists, social workers, child and adolescent mental health workers, child psychotherapists, family therapists, specialist teachers, a range of creative therapists and other allied health professionals. Community paediatricians also make a contribution to the service. Many services have not been able to recruit all members of a multi-disciplinary team, which limits their capacity to provide a comprehensive service.



- 9.6 A variety of therapeutic skills are needed, including behavioural, cognitive, interpersonal/psychodynamic, pharmacological and systemic approaches. These skills are not necessarily all vested in particular disciplines so that a combination of a skills-based and professional-based approach to team development is appropriate.

The commissioning process ensures that services are planned and developed on the basis of needs assessments and the capacity of local services to meet those needs.

*See section 10*

Services are resourced to address variations in staff availability, fluctuations in demand and training and the supervision needs of staff.

Commissioners and services ensure that professional and team isolation is avoided.

Services ensure that the requirement for a balance of direct and indirect work is reflected in the staffing levels and skills of the team and in individual workloads.

Services offer a comprehensive assessment and treatment service based on a skill mix drawn from professionals from the range of disciplines and therapeutic backgrounds.



### **Highly Specialised Services (Tier 4 Services)**

- 9.7** The prevalence of severe mental health disorder in children and young people is significant though relatively rare. It includes severe eating disorders, psychoses and major depression, with incidence increasing during adolescence.
- 9.8** Tier 4 CAMHS refers to the highly specialised provision that may be required by these children and young people. The different range and prevalence of serious disorders in childhood compared with adolescence means that services for these two broad age groups have to cater for a different range of needs, which need to be reflected in the specific skills of the staff working with them. The Department of Health has defined highly specialised services ([www.dh.gov.uk](http://www.dh.gov.uk)) for the minority of children and young people who may need them. The needs of the young people and their families may be met by these services in a variety of ways through intensive outpatient services, assertive outreach, inpatient psychiatric provision, residential and secure provision or other highly specialised assessment consultation and intervention services. Amongst the highly specialist services, inpatient psychiatric units for both children and adolescents, but separately provided to ensure that the developmental needs of different age ranges are met, are essential resources, representing 'the intensive care of child mental health'.
- 9.9** Due to the insufficient numbers of adolescent beds, some young people are being cared for inappropriately in adult psychiatric beds. In addition, children and young people who are psychotic or who have complex, persistent and severe behaviour disorders and who first present in accident and emergency departments may then be admitted to paediatric wards. A children's ward is not usually the best place for such patients, who may need to be in a children's or adolescent psychiatric unit or other appropriate, jointly agreed, alternative facilities as soon as possible.

- 9.10 *The National Service Framework for Mental Health*<sup>13</sup> has addressed the issues involved in providing safe care of sixteen and seventeen year olds, when they are admitted to adult mental health beds:- 'If a bed in an adolescent unit cannot be located for a young person, but admission is essential for the safety and welfare of the user or others, then care may be provided on an adult ward for a short period. As a contingency measure, NHS Trusts should identify wards or settings that would be better suited to meet the needs of young people. A protocol must be agreed between the child and adolescent mental health services and adult services. Protocols should set out procedures that safeguard the patient's safety and dignity.'
- 9.11 To some extent, whether or not highly specialist services need to be used is dependent upon the availability, quality, range and ability of Tier 2 and 3 services and other social care, education and youth justice services to deliver intensive support and intervention in the community. A further essential ingredient in effective provision for these children and adolescents is therefore the establishment of multi-agency agreements which clarify the level and scope of service provision.
- 9.12 A network of care is required in each locality for children and young people with severe, challenging and complex problems. This will promote collaborative working between services such as therapeutic fostering, pupil referral units, secure units, adolescent in-patient units and children's homes. Tier 3 and Tier 4 have a role in providing mental health services to secure units (e.g. secure children's homes, secure training centres and young offenders institutions), residential education and residential care, together with other intensive community settings, e.g. specialist fostering.

Multi-agency and specialist commissioning and planning shape Tier 4 services according to need and best practice, enabling the delivery of a volume of services that can encompass the challenges of demand, capacity, diversity and capability.

Emergency care, general and specialist in-patient services (e.g. eating disorders, forensic, medium secure and learning disability) are available for children and young people from each locality. There is a particular need to ensure the availability of beds into which emergencies can be admitted.

There are sufficient numbers of beds matched to need for each locality; i.e. patients who should be admitted on clinical grounds are not refused due to limitation of resources such as bed availability.

Primary Care Trusts and Local Authorities ensure that a network of care is developed in partnership for the provision of Tier 4 services and that written criteria for admission are available and are understood by professionals working with children and young people.

Tier 4 CAMHS work in collaboration with specialist education, social care and youth justice provision to provide a network of services for children and young people with severe, challenging and complex problems.

Primary Care Trusts and Local Authorities ensure that local networks of care are developed between Tier 3 and Tier 4 services to include assertive outreach and day care as well as inpatient and community services.

Specialist CAMHS are involved in the provision of mental health services to secure units, residential education and residential care, together with other intensive community settings (e.g. specialist fostering).

There is close collaboration and liaison with adult mental health services; transfer protocols between CAMHS and general adult psychiatric services are agreed and subject to audit. *See Standard 4*

When children and young people are unavoidably placed on paediatric or adult psychiatric wards, there is collaboration and joint working between the child health, adult mental health and CAMHS professionals. There is a shared aim to ensure a timely and appropriate placement, if required, in a child or adolescent inpatient unit.

Inpatient units ensure that they conform to a set of quality guidelines such as the *Quality Network for Inpatient Care* <sup>14</sup>

### **Discharge and Aftercare**

- 9.13** Discharge planning should receive equal attention to admission planning. Aftercare has a crucial role in the maintenance of treatment gains made during admission. In a minority of cases admission may be a stepping-stone towards longer-term alternative care or residential schooling. The team will need to liaise with a range of local education, social and mental health services.
- 9.14** The in-patient unit needs to be able to hand over to an appropriately equipped community service. There needs to be a shared understanding of the level of care required on discharge from inpatient services and if the appropriate resources are not available in community services, shared aftercare arrangements should be considered; there may be a continuing role for the in-patient team in the provision of outreach and after-care services.

The Care Programme Approach is used when young people are discharged back to community CAMHS or to appropriate adult services.

### **Supporting Staff**

- 9.15** The provision of mental health care for children and young people and their families can be emotionally demanding and stressful, particularly where there are high levels of risk. Support systems to enable staff to practice effectively and safely include the availability of supervision, appraisal, Continuing Professional Development (CPD) and mentoring.

Clear clinical and supervisory arrangements and structures are in place for all staff, to ensure accountable and safe service delivery.

Services ensure that all staff have CPD arrangements in place with professional development plans.

Services consider the value of staff mentoring, particularly for new members of staff.

## Evidence-Based Practice

- 9.16** The requirement to ensure an evidence-based approach to practice presents a particular challenge to professionals working in CAMHS. There is an increasing volume of robust research on the effectiveness of interventions; however, there are a number of limitations to the current research base for CAMHS in the United Kingdom. Children and young people rarely present with single disorders but rather with a range of problems. A large proportion of the available evidence does not reflect the co-morbidity issues which present in day-to-day clinical practice. In addition, services have to rely frequently on either extrapolating research findings from abroad or from adult literature. There are problems inherent in both these approaches. Psychological/behavioural interventions have received relatively little research attention and yet they constitute the main work of CAMHS professionals.
- 9.17** Lack of evidence of effectiveness does not equate to an intervention being ineffective. It may simply indicate that more research is needed to determine its effectiveness or otherwise. Innovative approaches should be encouraged but should be subject to audit and evaluation.

Services ensure that children and young people receive treatment interventions which are guided by the best available evidence and which take account of their individual needs and circumstances.



9.18 Up until recently, there has been little evidence available to inform the planning and delivery of multi-agency services. An increasing volume of information has now emerged regarding the factors that lead to successful multi-agency service provision in CAMHS<sup>15</sup>, see Box 3.

**Box 3 : Key Elements in a Service that “Works”**

Services need to have:

- > Strong inter-agency commitment over the medium to long-term, including a steering group or strategy group willing to tackle tricky issues, and a commitment to consulting with and acting on children’s and families’ views;
- > Links with existing services within CAMHS, including the integration of the service within the CAMHS tiered framework and CAMHS development strategy;
- > Links with other services and initiatives outside CAMHS e.g. education, the voluntary sector and area-based initiatives;
- > An ability to attract new sources of funding;
- > Retention of a stable, multidisciplinary staff group with opportunities for training and development;
- > Positive commitment to continued evaluation and audit, and
- > Balance between providing a direct service to users and influencing the broader network.

Primary Care Trusts and local authorities ensure that multi-agency service planning uses the best available evidence to ensure sustainable and effective services.

## Measuring Outcomes

- 9.19** It is important for the work of the child and adolescent mental services to be appropriately monitored and evaluated and the information used to enhance clinical work, to further service development and to inform users and other stakeholders. However, the processes of evaluation are complex, involving several parties and the tools and methods will need to continue to be developed over the next few years. Services may be supported by joining collaborations such as the CAMHS Outcome Research Consortium (CORC)  
[www.camhsoutcomeresearch.co.uk](http://www.camhsoutcomeresearch.co.uk)
- 9.20** The use of outcome measures will require the availability of basic throughput information on services (for example, number of referrals, new cases and on-going cases seen, number and types of staff available).

All services routinely audit and evaluate their work. Data collected is made available, in appropriate form, to clinicians, users and commissioners.

Resources, including administrative and clinical time and IT, are available so that routine evaluation of outcome can be carried out in all services.

As a minimum, all services evaluate outcome from the perspective of users (including where possible the referred child or young person themselves as well as key family members or carers) and providers of the service.

### **Appropriate and Safe Settings**

**9.21** Many CAMHS community services are poorly housed with insufficient space. Some services are poorly sited with regard to access for families by public transport. Others are also located in proximity to adult services (for example, drug and alcohol services) that may pose risks of harm to the children and young people using the CAMHS. Attention needs to be paid to the built environment for CAMHS including the development of provision in primary care, in schools and in other community settings. Services require appropriate facilities including furniture, telephones, IT and audiovisual equipment, one-way screens and play material.

Primary Care Trusts and local authorities ensure that services are offered in appropriate, safe, child-centred surroundings with the necessary facilities to ensure optimum professional practice.

Programmes for development of facilities take account of the Built Environment report.

### **10. Planning and Commissioning Services**

**10.1** Effective commissioning is a multi-agency activity that requires that the commissioners have the requisite skills, knowledge, time and executive responsibility to undertake the task.

**10.2** There should be full participation and ownership of the commissioning process by health, social services and education with participation as appropriate by other key partners such as youth justice. In many areas, this participation and ownership will be secured through the Children and Young People's Local Strategic Partnership, or equivalent body.

**10.3** The development of a multi-agency CAMHS strategy is essential for effective commissioning and service delivery and is a collaborative process between commissioners and providers.



- 10.4 The commissioning of appropriate services required for the delivery of the full range of services will be different, depending on the complexity of services and the level of need within a given population size. For highly specialised needs, collaborative commissioning arrangements need to be established.
- 10.5 The only services currently commissioned at a national level are those for forensic secure inpatient provision and highly specialist inpatient provision for deaf children and young people with mental health disorders. *See Standard 3*

Primary Care Trusts and Local Authorities ensure that a commissioning strategy (which also covers specialised commissioning) is in place for CAMHS. This is informed by a multi-agency assessment of need that is updated regularly. The needs assessment incorporates:

- > Locally adjusted epidemiological information on the prevalence of children's mental health problems to reflect the diversity of the population and other local demographic circumstances;
- > An assessment of the needs of particular groups of children and young people in the locality who are vulnerable or at risk of harm;
- > An audit of services currently provided by all agencies that address both directly and indirectly the mental health of children and young people;
- > An analysis of current service usage;
- > The views of all stakeholders including those of the children, young people and families;
- > The available evidence of the efficacy and effectiveness of interventions and service models, and
- > Current national and local policy priorities.

Commissioning ensures that the workforce is of sufficient size to have the capability to meet the range of defined needs safely, effectively and efficiently.

In order to provide adequate support to universal services and to prevent unnecessary admission to Tier 4 services, particular attention is paid to the capacity of Tier 3 services. *See Section 9*

Commissioners refer to the outcome of the *National Service Mapping Exercise*<sup>16</sup> that has provided information on the levels of service provision across the country. This information is useful for benchmarking the levels of staffing currently in place as elements of the desired comprehensive CAMH service.

In order to meet the needs of the very small number of children and young people with complex, severe and persistent problems that often consume large amounts of commissioner and provider time and effort, there are pre-emptive risk-sharing agreements on cost shares between local commissioning agencies.

Primary Care Trusts work together in consortia to ensure that highly specialised (Tier 4) services are commissioned. Strategic Health Authorities oversee and performance manage collaborative commissioning arrangements.

The continuing care needs of children and young people who receive highly specialised services is taken into account in the commissioning process.  
*See Standard 3*

## **11. Training and Development**

- 11.1** Providing high quality CAMHS is dependent on having sufficient numbers of appropriately trained staff to deliver high quality services in all four tiers, with a balanced skill mix to ensure the necessary range of skills. This will require a significant increase in the workforce in line with the guidance set out in section 9.
- 11.2** As part of the development of the workforce, it is important to identify any new or extended roles that might be appropriate to help deliver the expanded services, for example:
- > CAMHS Workers in Primary Care to act as a key link between primary care and specialist CAMHS services;
  - > New types of child and adolescent mental health workers;
  - > Extended roles for professionals acting as first on call in emergency and out-of-hours services;
  - > New support roles, and
  - > Paediatricians and general practitioners with a special interest in child mental health.
- 11.3** Services also need adequate management expertise to deliver multi-agency services and to have adequate access to support staff (for example, the administrative workforce should be sufficient to ensure that all necessary administrative functions, including data collection, can be fulfilled).

Primary Care Trusts, Local Authorities and services ensure that:

All staff working in universal services with children and young people have the Common Core skills, knowledge and competencies outlined in Standard 3. Multi-agency training is provided across schools, primary care, social care and youth justice.

Staff working in child and adolescent mental health services have the core competencies set out under Standard 3. In addition, joint training, continuing professional development and mentoring is needed to ensure that staff have the necessary skills and competencies to:

- > Work across agency boundaries and within a variety of settings;
- > Engage children, young people and their families who have difficulty accessing services, including those from black and minority ethnic groups;
- > Offer a range of modalities of treatment, including interpersonal, psychodynamic, systemic, cognitive behavioural therapies and psychiatric intervention, including the use of psychoactive medication, and
- > Deliver interventions based on the best available evidence. Where the evidence is limited, creative and innovative practice should also be encouraged, taking into account the views and wishes of the users of the service and subject to the process of audit and evaluation.

Specific training is also needed in the following areas:

- > Training for CAMHS professionals in developing areas such as learning disability, drug and alcohol misuse and use of psychoactive medication, cognitive behavioural therapy and other specific treatments;
- > Multi-agency and multi-disciplinary training for joint service provision across health, education and social care;
- > Shared training for professionals in the competencies required for “residential” care and for specialist treatments;
- > Training for those providing first on-call to children presenting with acute psychiatric illness in emergency and out-of-hours services;
- > Training for all staff working in accident and emergency departments who may carry out initial social and medical assessment of children with mental health problems;
- > Training for adult mental health professionals to enable them to be aware of the development needs of young adults making the transition across services;
- > Training for managers in providing multi-agency CAMHS services;
- > Training for commissioners in understanding CAMHS services (initially delivered by service providers), with the development of networks of CAMHS commissioners to help spread knowledge and best practice, and
- > Training in mental health legislation.

## Appendix 1

### A Note on Terminology

#### Mental Health

There are recognised difficulties in defining the problems that affect children and young people. The approach taken in *Together We Stand*<sup>17</sup> offers a consistent and widely agreed language and fits with the survey conducted by the Office for National Statistics<sup>18</sup> as follows:

*“Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behaviour. They are relatively common, and may or may not be persistent.”*

When these problems (conforming to the International Classification of Diseases (ICD)<sup>19</sup> criteria) are persistent, severe and affect functioning on a day-to-day basis they are defined as mental health disorders. In a small proportion of mental disorders, the term mental or psychiatric illness is used, to describe the very severe cases, for example, of depressive illness, psychotic disorders and anorexia nervosa. The Audit Commission report *Children in Mind*<sup>20</sup> found that many children presented to CAMHS with more than one condition, and up to five presenting complaints. It is common to find the presence of co-morbidity (more than one mental health disorder present, e.g. attention deficit hyperactivity disorder (ADHD) and depression, or ADHD and conduct disorder) which increases the challenge and complexity of the care and treatment required for children and young people in the community.

#### What is CAMHS?

The term CAMHS (Child and Adolescent Mental Health Services) is used in two different ways. One is a broad concept embracing all services that contribute to the mental health care of children and young people, whether provided by health, education, social services or other agencies. Hence it includes those services whose primary function is not mental health care e.g. general practice or schools, referred to as Tier 1 or universal services ( see ‘The Four Tier Strategic Framework’). The other applies specifically to specialist child and adolescent mental health services at Tiers 2, 3 and 4, and also including specialist social care, educational, voluntary and independent provision for children and young people with mental health problems. For these services, the provision of mental health care to children and young people is their primary function. They are mainly composed of a multidisciplinary workforce with specialist training in child and adolescent mental health. In this National Service Framework, the term CAMHS is used to refer to the broader service concept, and specialist CAMHS to refer to the latter.

CAMHS cover all types of provision and intervention from mental health promotion and primary prevention, specialist community-based services through to very specialist care as provided by in-patient units for young people with mental illness (Tiers 1-4). Interventions may be indirect (e.g. consultative advice to another agency) or direct (e.g. direct therapeutic work with an individual child or family). Services for children, young people and their families in Tier 1, will focus on the initial assessment and identification of difficulties and may include advice or the provision of therapeutic help that does not require intensive specialist training or onward referral. The nature, severity, complexity and specificity of the child's mental health problem will help determine where the child is best seen and by which service. Specialist services may be offered in a range of settings according to need and availability, often in partnership with other agencies, including in community locations, out-patient clinics, day and in-patient units and the family's home. Specialist CAMHS will provide a range of assessment and treatment options singly or in combination, utilising the skills of multi-disciplinary teams. Where the problems are uncommon or particularly complex, the child or young person may require referral on to highly specialist Tier 4 services.

### **The Four Tier Strategic Framework**

In 1995, the NHS Health Advisory Service published a thematic review of CAMHS<sup>17</sup>, which described a four-tier framework (see Box 4 for an example of how the framework can be described). Later work on CAMHS carried out by the Audit Commission<sup>20</sup> took the four-tier strategic approach as its baseline and its report confirmed the applicability of this approach to future planning. Although there is some variation in the way in which the tiered strategic framework has been developed and applied across the UK it has created a common language for describing and commissioning services.

Where services are described in this NSF, references have been made to the four-tier framework. But it is important to stress, that whilst the framework is a useful conceptual tool, it should not be seen as something constraining or limiting. Neither services nor people will fall neatly into tiers and nor should they. Similarly, there is a misconception that a child or young person will move up through the tiers as their condition is recognised as more complex. In reality, there will be some children and young people that may require services from a number, or even all of the tiers, at the same time.

**Box 4 : The Four Tier Strategic Framework**

Tier	Professionals Providing the Service Include
<b>Tier 1</b> A primary level of care	<ul style="list-style-type: none"> <li>• GPs</li> <li>• Health visitors</li> <li>• School nurses</li> <li>• Social workers</li> <li>• Teachers</li> <li>• Juvenile justice workers</li> <li>• Voluntary agencies</li> <li>• Social services</li> </ul>
<b>Tier 2</b> A service provided by professionals relating to workers in primary care	<ul style="list-style-type: none"> <li>• Child and Adolescent Mental Health workers</li> <li>• Clinical child psychologists</li> <li>• Paediatricians (especially community)</li> <li>• Educational psychologists</li> <li>• Child &amp; adolescent psychiatrists</li> <li>• Child and adolescent psychotherapists</li> <li>• Community nurses/nurse specialists</li> <li>• Family therapists</li> </ul>
<b>Tier 3</b> A specialised service for more severe, complex or persistent disorders	<ul style="list-style-type: none"> <li>• Child &amp; adolescent psychiatrists</li> <li>• Clinical child psychologists</li> <li>• Nurses (community or in-patient)</li> <li>• Child psychotherapists</li> <li>• Occupational therapists</li> <li>• Speech and language therapists</li> <li>• Art, music and drama therapists</li> <li>• Family therapists</li> </ul>
<b>Tier 4</b> Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units	<ul style="list-style-type: none"> <li>• Child &amp; adolescent psychiatrists</li> <li>• Clinical child psychologists</li> <li>• Nurses (community or in-patient)</li> <li>• Child psychotherapists</li> <li>• Occupational therapists</li> <li>• Speech and language therapists</li> <li>• Art, music and drama therapists</li> <li>• Family therapists</li> </ul>

Function/Service
CAMHS at this level are provided by professionals working in universal services who are in a position to: <ul style="list-style-type: none"> <li>• Identify mental health problems early in their development</li> <li>• Offer general advice</li> <li>• Pursue opportunities for mental health promotion and prevention</li> </ul>
CAMHS professionals should be able to offer: <ul style="list-style-type: none"> <li>• Training and consultation to other professionals (who might be within T1)</li> <li>• Consultation to professionals and families</li> <li>• Outreach</li> <li>• Assessment</li> </ul>
Services offer: <ul style="list-style-type: none"> <li>• Assessment and treatment</li> <li>• Assessment for referrals to T4</li> <li>• Contributions to the services, consultation and training at T1 and 2.</li> </ul>
<ul style="list-style-type: none"> <li>• Child and adolescent in-patient units</li> <li>• Secure forensic units</li> <li>• Eating disorders units</li> <li>• Specialist teams (eg. for sexual abuse)</li> <li>• Specialist teams for neuro-psychiatric problems</li> </ul>



## Appendix 2 A Comprehensive CAMHS

*Improvement, Expansion and Reform* <sup>1</sup> has set the expectation that a comprehensive child and adolescent mental health service (CAMHS) will be available in all areas by 2006. This means that in any locality, there is clarity about how the full range of users' needs are to be met, whether it be the provision of advice for minor problems or the arrangements for admitting to hospital a young person with serious mental illness. This is reiterated in *National Standards, Local Action* <sup>2</sup>, which sets out the priorities for 2005/06-2007/08 for the NHS, and emphasises the need to maintain the levels of service achieved through the 2003-06 planning round.

Clear pathways should be set out to show how the range of mental health needs of children and young people will be met, whether from within services whose prime purpose is to deliver mental health care or from other services with a different primary function. This will not necessarily mean that all services will be in their final configuration or available in every locality by 2006. Where local provision is not appropriate or possible, commissioners will need to set out the collaborative arrangements that will ensure that there is an agreed care pathway to meet the specific needs from an alternative service. Further improvements and developments will be required throughout the lifetime of the National Service Framework implementation to extend the range of services provided and ensure the highest standards of care. The aspiration should be to continually improve and develop the services in the context of multi-agency partnerships across the spectrum of need, and informed by the best available evidence.



## **A comprehensive service in practice**

Commissioners will require a clear definition and description of a comprehensive CAMHS. This can be set out under a number of separate headings:

### **Underpinning Principles:**

- > Access to CAMHS should be available to all children and young people regardless of their age, gender, race, religion, ability, class, culture, ethnicity or sexuality.
- > Effective CAMHS commissioning is a multi-agency activity and requires that the commissioners have the requisite skills, knowledge, time and executive authority to undertake the task.
- > Both the commissioning and delivery of services should be informed by a multi-agency assessment of need that is updated regularly. This needs to incorporate:
  - Locally adjusted epidemiological information on the prevalence of children's mental health problems to reflect the diversity of the population and other local demographic circumstances.
  - An assessment of the needs of particular groups of children and young people in the locality who are vulnerable or at risk
  - An audit of services currently provided by all agencies that address both directly and indirectly the mental health needs of children and young people.
  - An analysis of current service usage.
  - The views of all stakeholders including those of the children, young people and families.
  - The available evidence of the efficacy and effectiveness of interventions and service models.
  - Current national and local policy priorities.
- > Services should be commissioned to ensure that the workforce is of sufficient critical mass to have the capability to meet the range of defined needs safely, effectively and efficiently.

**Range of Services:**

- > The range of services and their settings should reflect the specific needs:
  - Related to the age of children and young people using the service
  - Related to the circumstances of the child, particularly if they may affect access to services
  - Associated with the presence of a learning disability.
- > Arrangements should be in place to ensure that 24 hour cover is provided to meet urgent needs and a specialist mental health assessment should be undertaken within 24 hours or during the next working day.
- > There needs to be a balance of service provision in order that all levels of need can be met as required:
  - Within primary level services (Tier 1), those in contact with children need to be able to have sufficient knowledge of children's mental health to be able to: identify those who need help; offer advice and support to those with mild or minor problems; and have sufficient knowledge of specialist services to be able to refer on appropriately when necessary.
  - Child mental health workers (Tier 2) need to be available to support, train, liaise with, consult to and provide direct work with other agencies providing services for children.
  - Specialist multidisciplinary teams in all localities should be able to provide:
    - Specialist assessment and treatment services
    - Services for the full range of mental disorders in conjunction with other agencies as appropriate.
    - A mix of short term and long term interventions and care according to levels of complexity, co-morbidity and chronicity.
    - A full range of evidence-based treatments;
    - Specialist services that are commissioned on a regional or multi-district basis, including in-patient care

### **Workforce and Skills:**

- > The professional mix within specialist services and teams should be balanced to ensure the availability of an appropriate representation of skills, in particular, professional and team isolation should be avoided in all services.
- > Staff have the skills, competencies and capabilities that are necessary. All services should ensure they can:
  - Work across agency boundaries and within a variety of settings;
  - Engage children, young people and their families who have difficulty accessing services.
  - Deliver interventions based on the best available evidence.
- > Services require management expertise with sufficient knowledge, understanding and executive authority to be able to support the effective and efficient multi-agency delivery of CAMHS.
- > The administrative workforce should be sufficient to ensure that all necessary administrative functions, including data collection, can be fulfilled.
- > Commissioners in conjunction with specialist providers should support the development of CAMH expertise within all children's agencies.

### **Training and development:**

- > Clear supervisory arrangements and structures should be in place to ensure accountable and safe service delivery.
- > Multi-professional training and consultative work, undertaken both within and across agencies, is essential.
- > The necessary resources to support the training and development requirements of the CAMHS workforce should be available.

**Organisational arrangements:**

- > Agreed protocols should be in place to manage waiting lists and times according to need.
- > Services should be accommodated in buildings fit for supporting all the expected functions.
- > Where services are located in non-CAMHS dedicated community settings (e.g. schools), arrangements should be made to provide suitable accommodation for supporting service delivery.
- > The equipment and accommodation used for direct work with children should ensure that children's safety is of paramount concern.
- > IT resources and equipment to support high quality care and the monitoring and evaluation of services should be available in all appropriate settings.
- > Where interfaces exist between services, as between adult and children's mental health services, arrangements should be negotiated to ensure clarity and effectiveness of separate and joint service responsibilities and smooth transitions of care.
- > Where service delivery demands effective partnerships between agencies (e.g. children and young people with complex, persistent and severe behavioural disorders) joint protocols should be agreed at senior officer level between the NHS, social services and education.
- > Clinical governance arrangements should ensure that all staff are trained, supported and able to deliver sound, ethical and safe services.



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# Mental Health & Psychological Well-Being of Children and Young People External Working Group Members

## Chairs

### **Caroline Lindsey**

Consultant, Child and Adolescent Psychiatrist,  
Tavistock Clinic, London

### **Mike Farrar**

Chief Executive, South Yorkshire Strategic Health  
Authority

## Members

### **Susan Bailey**

Consultant Adolescent Forensic Psychiatrist and  
Professor of Child and Adolescent Forensic  
Mental Health, University of Central Lancashire.

### **Ricky Emanuel**

Consultant Child Psychotherapist, Royal Free  
Hospital, London

### **Hugh Firth**

Consultant Clinical Psychologist, Northgate and  
Prudhoe NHS Trust, Northumberland

### **Ian Gale**

Consultant Child Psychologist, Northgate and  
Prudhoe NHS Trust, Northumberland

### **Elena Garralda**

Consultant Child and Adolescent Psychiatrist,  
CNWL Mental Health NHS Trust, Professor of  
Child and Adolescent Psychiatry, Imperial College  
London (Division of Neurosciences and  
Psychological Medicine)

### **Simon Gowers**

Consultant Adolescent Psychiatrist, Pine Lodge  
Young People's Centre, Chester and Professor of  
Adolescence Psychiatry, University of Liverpool

### **Peter Griffiths**

Child and Adolescent Mental Health Nurse,  
Tavistock Clinic/Middlesex University, London  
(currently, Senior Lecturer in Child & Family  
Mental Health Nursing, Tavistock Clinic)

### **Stephen Grigg**

Educational Psychologist, City of York

### **Jane Held**

Director of Social Services, Camden Council,  
London (currently, Interim Director of  
Regulations, General Social Care Council)

### **Carol Joughin**

Former Project Manager, Focus, Royal College of  
Psychiatrists and DH editorial team

### **Martin Knapp**

Professor of Social Policy and Professor of Health  
Economics, Personal Social Services Research  
Unit, London School of Economics

### **Philip Messent**

Family Therapist, Emmanuel Miller Centre,  
London

### **Dawn Rees**

CAMHS Regional Development Worker (East) as  
part of the National CAMHS Support Service

### **Ken Sampson**

Lead Child Mental Health Nurse, Cornwall Child  
and Family Service, Cornwall



**Paul Schatzberger**

General Practitioner, Sheffield North Primary Care Trust, Sheffield

**Neela Shabde**

Community Paediatrician, Albion Road Clinic, North Shields, Tyne & Wear

**Dianne Smith**

South Yorkshire Health Authority, Sheffield

**Richard Williams**

Professor of Mental Health Strategy, University of Glamorgan and Consultant Child and Adolescent Psychiatrist in Gwent Healthcare NHS Trust

**Peter Wilson**

Former Director, YoungMinds, London

**Miranda Wolpert**

Consultant Clinical Psychologist, Bedfordshire and Luton NHS Trust, Dunstable (currently, National Institute of Mental Health in England Fellow in Child and Adolescent Mental Health - jointly appointed by NIMHE and YoungMinds)

**DH/DfES officials**

Michele Armstrong, Geoffrey Baruch, Geoff Dent, Keith Escott, Imelda Giarchi, Claire Hartley, Cathy James, Bob Jezzard, Helen Kay, Claire Phillips, David Roberts, Peter Smith, Caroline Twitchett, Kathryn Tyson

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DH Publications Orderline

PO Box 777

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