

department for

**education and skills**



*Promoting the Mental Health and Psychological Well-being of Children and Young People*

**Report on the  
Implementation of  
Standard 9 of the  
National Service  
Framework for  
Children, Young People  
and Maternity Services**

*Change for Children - Every Child Matters*

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## Standard 9

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**Report on the Implementation of Standard 9 of the  
National Service Framework for Children, Young People and  
Maternity Services**

# Foreword

We are publishing this document to report on progress in improving the mental health and psychological well-being of children and young people. The report highlights some areas on which service providers and commissioners will need to focus if the ten-year objectives set out in Standard 9 of the Children's National Service Framework (NSF) are to be achieved, and offers best practice guidance to assist achievement.

It is vital that we continue and extend recent initiatives to improve the psychological well-being of children and young people in order that their full potential can be realised. Good mental health is important in helping to strengthen families, improve educational attainment, promote social inclusion, tackle anti-social and offending behaviour, expand individuals' opportunities and improve their general health and well-being.

As emphasised by Every Child Matters (ECM), these outcomes are all inter-related. The wider ECM agenda is important in providing a framework within which mental health and psychological well-being, as envisaged in the NSF, can be promoted. Everyone who works with children needs to have a clear understanding of what they can contribute to a child's mental and physical health and development. This means local children's services and Child and Adolescent Mental Health Services (CAMHS) teams engaging with each other to plan and develop patterns of joint working which reflect both their respective expertise and their shared responsibility. This document is therefore aimed at the CAMHS community as well as a much wider readership, including commissioners of mental health services for children and young people and adults, the Primary Care Trusts (PCTs) and Local Authorities, Specialist Commissioners and Strategic Health Authorities (SHAs).

The importance which the Government attaches to good mental health in children and young people is demonstrated by the additional resources which have been directed towards these services in recent years. In return for this investment, Government has set a Public Service Agreement (PSA) target that a comprehensive CAMHS should be commissioned in all parts of England by the end of 2006. For the reasons set out in this report, this is a very challenging target, and it will require continued, sustained efforts on the part of many people if it is to be achieved. However it is also true that CAMHS have come a very long way in a short period of time, demonstrating a remarkable ability to improve the service provided to children and families.

It is important that we do not lose the momentum which has characterised the improvements to CAMHS so far. The PSA target is only an interim milestone in the pathway to the standard set out in the NSF. We all therefore need to be looking beyond the PSA target to identify next steps in achieving medium-term improvements to CAMHS. The NHS is going through a period of unprecedented change as we move to a patient-led service, one which places a greater emphasis on primary care, and where historic financial deficits are eliminated. In the short term the structural changes which underpin this system reform may pose challenges for some CAMHS. We hope that the clear vision set out in this report will provide a sense of direction to sustain CAMHS and guide the commissioning and provision of services at this time.

We would like to record our thanks to Caroline Lindsey for her tireless work in leading the researching and production of this report and to all who have contributed the evidence which supports it, in particular the Regional Development Workers of the National CAMHS Support Service. We also pay tribute to all the dedicated staff involved in commissioning and providing services across a wide range of agencies, who are helping to improve the mental health and emotional well-being of children and young people: from the contribution made by primary care teams, teachers, and youth justice teams to those who work with some of the most severely ill adolescents. Their task is often not easy and needs to be recognised for what it is: incredibly valuable.

There have been significant advances in Child and Adolescent Mental Health Services (CAMHS) in a relatively short period of time. To ensure that CAMHS continues to contribute to Government priorities for improving life chances for children and young people, it is important that the momentum of service development be sustained. There is still a long way to go before the standards set out in the NSF are achieved. In the short term commissioners and service providers are focusing on the achievement of the PSA target, which has helped to drive progress. This is also the time when the planning of medium-term service improvements needs to begin.



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# Executive summary

## Improving the delivery of good practice in the medium-term

The NSF is a ten-year development plan covering the whole spectrum of issues. In taking forward the NSF, local CAMHS commissioners and providers are starting from different baselines, with the current provision of CAMHS varying from one area to another. Their priorities for development at any one time will differ accordingly. In all cases however, implementing such an ambitious programme of service improvement will require a sustained and concerted effort by commissioners and providers of CAMH services. The following recommendations summarise the extent of progress which CAMHS should expect to achieve by the mid-point in the NSF cycle in order to achieve the full programme.

- Services build on the achievement of the PSA target for young people with learning disabilities, 16 and 17 year olds, and 24 hour cover and next day specialist assessment, so that services are sustainable and locally-provided.
- Commissioners and providers of services are recruiting sufficient staff and developing the skill mix, capability and competencies to deliver all the assessment and treatment components of comprehensive CAMHS leading in turn to improved access and reduce waiting times and the elimination of unacceptable variations in service provision between different geographical areas.
- Clear and strong leadership is provided to develop and deliver a high quality, multi-agency CAMHS Strategy.

- Local agencies promote children's psychological well-being by delivering services which promote the mental health of mothers, particularly in the pre- and post-natal period. They address this within education, through support for parenting, especially for vulnerable groups, and through early years' and youth services.
- All front-line professionals in the children's workforce, including teachers and community health care staff, social workers, nurses and GPs are trained to promote children's mental health, to recognise problems as they are developing and to consult with and refer onto mental health professionals where necessary. Specialist CAMHS to continue to expand its input to and support for this, including via new settings such as Children's Centres and Extended Schools.
- Child mental health education is available on all pre- and post registration professional training courses and supplemented by in-house training provided locally according to assessed need.
- The Healthy Schools programme is fully implemented by 2009, and schools and other settings promote the psychological well-being of all children.
- Child and adolescent mental health is part of the core training for all nurses, paediatricians, social workers and teachers.
- The Care Programme Approach (CPA) is adapted for transition planning to AMH services.
- Use of adult wards is eliminated for all but a few older adolescents who identify more readily with young adults.
- Early Intervention Services for Psychosis are appropriately staffed to collaborate and provide services, for the full age range within their remit, including under 18s.
- CAMHS, AMH and LA Commissioners work in partnership to create networks of services for young people which involve CAMHS, AMH, social care and leaving care teams, youth employment, advocacy services, housing, Connexions/youth teams and youth offending teams, and the voluntary sector.

- Complex needs are met locally, and by community-based teams where possible.
- Robust specialist commissioning arrangements for the NHS and Local Authority provide a secure basis for the development and delivery of low volume services, including in-patient units, intensive outreach teams and multi-agency services for young people with the most complex needs.
- Commissioners of paediatric services and CAMHS collaborate to ensure that a Paediatric Liaison service is provided with agreed apportioning of costs to the relevant budgets.
- Dedicated services for children in care, and those in the Youth Justice system, are commissioned and further developed.
- The needs of black and minority ethnic groups in each community are addressed at all levels of provision.
- Support is available for the further development and refinement of tools for Routine Outcome Monitoring (ROM), and commissioners ensure that services develop ROM by provision of adequate administrative resources.
- Nationally and locally Cognitive Behavioural Therapy (CBT) training and supervision is developed to enable CAMHS to meet National Institute for Health and Clinical Excellence (NICE) guidance.
- Local service planners take a strategic overview in order for CAMHS to offer a coordinated response to the totality of NICE guidance.
- Services are working in fit-for-purpose buildings in locations which offer good public transport access for patients.
- User participation improves, more choices are offered to children and families, and the pattern of service delivery reflects users' preferences.

# Introduction

Mental illness is a serious problem among children and young people, with one in ten experiencing some form of diagnosable mental disorder. The proportion of children with mental health problems is higher now than it was 30 years ago<sup>1</sup>, though the prevalence showed no increase between 1999 and 2004<sup>2</sup>.

The National Service Framework (NSF) for Children, Young People and Maternity Services was published in September 2004. Standard 9 of the NSF<sup>3</sup> articulated the vision for the mental health and psychological well-being of children and young people:

## NSF Vision

We want to see:

- An improvement in the mental health of all children and young people.
- 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.
- 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.

The NSF provided a detailed definition of a comprehensive CAMHS which is the strategic objective towards which commissioners and providers of services need to be working.

The planning framework issued by the Department of Health for the NHS, Improvement, Expansion and Reform (2002), set the expectation that comprehensive CAMHS would be available in all areas by 2006. In practice, this means that in every locality, commissioners, in consultation with providers, should ensure that it is clear to users and referrers, how the full range of users' needs is to be met. National Standards, Local Action 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 provided, whether from within services whose prime purpose is to deliver mental health care (specialist CAMHS) or from other services with a different principal purpose. CAMHS includes the range of multi-agency and multidisciplinary services for children, young people and their families which promote and improve mental health and psychological well-being. The services extend from education and community primary care through to highly specialised services and should be available and accessible to all those needing them.

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; i.e. a clear and comprehensive network of services, with identified pathways into and across the services, delivered collaboratively, must be jointly commissioned and available in each region to meet the likely range of needs, by December 2006.

Key components of a care pathway are:

**Recognition** – definition of problem/concern, community awareness, education and training about the condition-audit of prevalence and of unmet need

**Role and remit of agencies** defined across the pathway

**Referral processes** – non- duplication of assessments and interventions, protocols, threshold criteria, waiting times, location and range of services

**Assessment, Diagnosis and Treatment** – effective use of resources, interventions at the level of child, family and agency, range of assessment tools, range of modalities of treatment provided by trained staff, NICE guidelines, referral on to other more specialised services, outcome monitoring

**Multi-agency working** – establishment of inter-agency partnerships at organisational and case level; collaboration across the range of multi-agency services, joint working, information sharing protocols, lead professionals

**On-going care** – follow up, discharge planning, re-entry arrangements, transition arrangements

An example of a care pathway for Attention Deficit Hyperactivity Disorder (ADHD) has been published by HASCAS<sup>5</sup>. The Do Once And Share (DOAS) Project has also developed a Learning Disability care pathway (June 2006).

A continual process of improvement and development to CAMHS will be required throughout the lifetime of the National Service Framework to extend the range of services provided and ensure the highest standards of care. This will only be achieved by multi-agency partnerships, which are informed by the best available evidence, working across the spectrum of need.

This report sets out:

- the progress towards the vision,
- the challenges which remain, and especially
- those areas where there will need to be particular progress in the medium-term in order to deliver the NSF's ten-year programme.

For each area of service provision, the report looks at current progress, summarises the NSF requirement, and highlights the issues providers and commissioners need to look at in developing their services. The annex contains examples of services which are already demonstrating good practice.

## Progress to date

The mapping of CAMHS<sup>6</sup> which is carried out annually by the University of Durham for the Department of Health confirms the improvement in CAMHS over recent years. Some of the most marked trends shown in the Mapping results for 2005 are:

- Expenditure on CAMHS, as recorded in the mapping, has risen from £284m in 2002/03 to an estimated £513m in 2005/06, an increase of over 80 per cent.
- An increase in CAMHS staffing<sup>7</sup> over the period 2003-2005 of 2,115 Whole Time Equivalents (WTEs) equal to 27 per cent: (7,761 WTE in 2003; 8,894 WTE in 2004, 9,876 WTE in 2005).
- CAMHS have been seeing more cases: an increase in total caseload of 32,382 cases from 2002-2005 (40 per cent) and an increase of 21,508 new cases between 2002 and 2005 (219 per cent).
- Children and families are being seen sooner. Cases waiting to be seen fell by 15 per cent between 2004 and 2005; 30,660 cases were waiting to be seen in 2004 and this fell by 4,476 to 26,207 in 2005.

While CAMHS have been improving steadily for a number of years, the pace of development has dramatically increased since 2002. The increase in investment and staffing in the period up to 2005/06, though important, needs to be set against the fact that a significant proportion of children who could benefit are still not receiving services. Research has shown that only 25 per cent of children with a diagnosed psychiatric disorder were accessing mental health services over a three year period. Although some of the remaining children may have been receiving appropriate support from other professionals, clearly, some children would have benefited from accessing a more specialist service. This has implications for the support and training of all staff working with children and their families. 43 per cent did not have contact with any professional<sup>8</sup>.

The mapping and other sources of information show very graphically that service provision and access vary between different parts of the country. This reflects differential levels of investment in CAMHS across the country. While it is undoubtedly true that CAMHS in general have improved in recent years, the slow rate of progress in some areas means that not all children and families are benefiting as they should. One of the goals of the NSF is to ensure greater equity of access to CAMHS for children and young people in all parts of the country.

It is crucial that, if we are to secure improved outcomes for all children, there is continuing collaboration between all partner agencies providing mental health services for children, young people and their families. It is also vital that CAMHS are sustained through the commissioning process to meet the expectation of a modernised, effective, accessible and responsive service.

## Short term priorities

This section of the report looks at three of the areas where CAMHS need to make significant progress in the short term. The next section looks at issues for CAMHS development over the medium term, that is to 2009.

The Department of Health has set a Public Service Agreement target that comprehensive CAMHS will be available to all who need them across England by the end of 2006. This is a very challenging target for the NHS and Local Authorities, but is an essential milestone in ensuring that children and young people receive the help they need to develop their full potential. For the purposes of assessing the extent to which this is achieved, three proxy measures have been identified for the NHS:

- 24 hour cover available for urgent needs and specialist assessments undertaken within 24 hours or during the next working day;
- Full range of CAMHS available or accessible for children and young people with learning disabilities; and
- Services available for all 16 and 17 year olds appropriate to their age and level of maturity.

Local Authorities have a similar performance indicator that includes these three dimensions and one additional question:

" Were protocols in place for your council area for partnership working between agencies for children and young people with complex, persistent and severe behavioural disorders?"

There is a separate DH target on the development of teams for Early Intervention in Psychosis (EIP) for 14-35 year olds. The NHS is expected to ensure that 7,500 new patients receive quick diagnosis of the first onset of a psychotic disorder and appropriate treatment in 2006/07. While this is not solely concerned with adolescents, young people are clearly part of the user group for this service.

## 24 Hour and Emergency Cover

For children and young people who are experiencing a mental health crisis it is important that CAMHS are able to provide the appropriate support promptly, either direct or via partner agencies. It is also important, once the immediate needs are met, that the young person and their parents or carers receive the appropriate, on-going help.

### Progress in developing services

At the end of June 2006, over 85 per cent of Primary Care Trusts (PCTs) were commissioning 24 hour and emergency services in contrast to 2002 when fewer than half of providers had on-call services. Only seven services out of 138 now have no on-call or next day assessment services.

### NSF Marker of Good Practice

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.

### Delivering Good Practice

- Specialist CAMHS assessments are available within 24 hours or the next working day.
- A specialist CAMHS second on-call arrangement supports the staff who make the initial assessment. This will be achieved in well-resourced centres, where there are child psychiatry training rotations, or where there are in-patient units. Where the local service is unable on its own to provide adequate psychiatric out of hours cover, arrangements are made to commission rotas across several providers, with neighbouring services, and adult mental health services.
- First on-call arrangements do not rely on Consultant Child and Adolescent Psychiatrists to provide an out of hours first on-call service as this would tend to have an adverse effect on day-time provision of Child Psychiatric services.

- Rotas are of a size that is sustainable.
- A rota of Child and Adolescent Psychiatrists who are approved under Section 12 of the Mental Health Act (MHA) 1983 is available out of hours to address the needs of those young people who require compulsory admission.
- Children's Social Workers who are also Approved Social Workers under the terms of the MHA1983 are available to work with Section 12 approved doctors, when required for young people under the age of 18 years.
- The arrangements for cover are supported by a protocol and the incidence of emergencies and their outcomes audited.
- All staff involved in the on-call rota receive ongoing training and supervision.
- Children and young people under 16 who have self harmed are triaged, assessed and treated in a separate children's area of A and E.
- Paediatric beds, supported where necessary by mental health nurses are available for cases of self-harm for under-16s.
- Clear protocols for the management of social work emergencies and for emergency placements out of hours are agreed by Local Authority Children's Services, CAMHS and Acute Hospital Trusts in order to meet the needs of young people who present as emergencies either because of exhibiting severe behavioural difficulties, or because they are at risk through delinquency, drug taking, abuse or domestic violence.

### **Services and transitional arrangements for young people**

The incidence of mental health problems, especially more serious conditions, is higher among adolescents than in younger children. Services for older adolescents have to be able to meet these needs, and to do so in an environment which service users feel is appropriate to their age and development. A setting which appears geared either to younger children or to adults but not to adolescents is unlikely to meet their expectations. Some adolescent users of CAMHS will continue to need mental health services past their 18th birthday and for these young people, there needs to be a smooth transition to adult services.

#### **Progress in developing services**

At the end of June 2006, 78 per cent of Primary Care Trusts (PCTs) were commissioning services for 16 and 17 year olds. In 2005, 955 teams out of 1051 (91 per cent) had an upper age limit of 16 or above, and teams with an upper age limit of 17 or above increased from 677 (68 per cent) in 2004 to 755 (72 per cent) in 2005.

Flexible working between CAMHS and AMH is particularly important to delivering effective services for this age group and there are many good examples of this: services have appointed transitional workers to aid the transfer to adult services and there are developments of youth and young adult services both within voluntary services and in the NHS. A recent audit (Lamb, C, 2006) showed that in England, there were 14 teams dedicated to older adolescents in 1999, 19 teams in 2001 and 31 teams in 2005.

However, many young people who have received a service from CAMHS do not fit the criteria for ongoing care in AMH. Many service protocols imply that young people who have been treated by CAMHS, but do not fit the criteria for adult services (for example, those with ADHD, Autistic Spectrum Disorder, those with emerging personality disorders and attachment disorders), should be discharged back to their GP when they reach 18.

Many adult mental health services consider that they do not have either the workforce or skills to work with this younger age group, while CAMHS professionals consider that they need the advice and experience of Adult Mental Health professionals in dealing with aspects of the care required for young people in prodromal or early stages of enduring mental illness. Across AMHS and CAMHS, there is therefore a need for collaborative working and mutual training and consultation.

### **NSF Markers of Good Practice**

CAMHS are able to meet the needs of all young people including those aged 16 and 17.

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.

### **Delivering Good Practice**

- AMH and CAMHS commissioners with their LA partners, together with local agencies, act in partnership to plan joined up, multi-agency, young people's services. These partnerships include adult mental health and child and adolescent mental health, social care and leaving care teams, youth employment, advocacy services, housing, Connexions / youth teams and youth offending teams, young people's health services including sexual health and substance misuse services, and the voluntary sector. They involve users and ensure that they take into account the needs of local black and minority ethnic communities.
- The buildings from which teams work, provide accessible and age appropriate settings.

- The Care Programme Approach (CPA), modified to meet the needs of younger people, is used to plan transition, and transition is supported by agreed protocols.
- Arrangements exist for alternative provision to meet the on-going need of young people who do not meet the criteria for AMH, for example, either by specific packages of care or by using other local voluntary community services.

### **Early Intervention for Psychosis Teams (EIP)**

Early Intervention for Psychosis teams have been established for 14-35 year olds in order to:

- reduce the stigma of psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment
- reduce the length of time young people remain undiagnosed and untreated by ensuring early detection of psychosis and early access to services
- develop meaningful engagement, provide evidence-based interventions and promote recovery during the early stages of illness
- increase stability in the lives of service users, facilitate development and provide opportunities for personal fulfilment
- provide a user- centred service
- at the end of the treatment period, ensure that the care is transferred thoughtfully and effectively

## **Progress in developing services**

The NHS made rapid progress in establishing an initial tranche of EIP teams, achieving 109 teams by December 2004 against a target of 50. Delays in establishing teams in some parts of the country and a slower-than-expected build-up of caseload led to a revision of the plans for growth in caseload over a three-year period. However, not all EIP teams include CAMHS staff and the extent of coordination between EIP teams and CAMHS varies widely.

## **Delivering Good Practice**

- EIP teams are appropriately staffed to collaborate and provide services, for the full age range within their remit
- EIPs are working with under-18s
- CAMHS staff working in the EIP teams facilitate integrated practice between AMH and CAMHS
- EIPs and CAMHS coordinate their work to ensure the best outcomes for the young people in their care.

### **CAMHS for children and young people with learning disabilities (LD)**

The incidence of mental health problems among children with a learning disability is four times higher than for other children and the incidence is even higher for children with a severe learning disability. However access to CAMHS is more limited for these groups than for children and young people without a learning disability. This striking imbalance between need and provision underlines the urgent need to improve services.

#### **Progress in developing services**

At the end of June 2006, 59 per cent of PCTs were commissioning CAMHS for children and young people with learning disabilities. This represents an increase of almost half compared to the position at the end of 2004/05. The number of children with LD seen rose from 8764 in 2004 to 9538 in 2005 accounting for 8 per cent of the total caseload.

This is the most challenging of the proxy measures for local commissioners and providers to achieve because of the scale of the shortfall and the extent of workforce issues to be addressed in meeting this aspect of the PSA target.

#### **NSF Marker of Good Practice**

All children and young people with both a learning disability and a mental health disorder have access to appropriate CAMHS.

## Delivering Good Practice

Commissioners and providers collaborate to:

- map current provision and ensure coordination between health, education, social services and the voluntary sector;
- preserve existing specialist capacity and expand upon resources;
- clarify CAMHS pathways for children with a learning disability, their families and carers;
- identify and meet training needs

## CAMHS development in the medium-term

The proxy measures discussed in the previous section represent some of the areas in which CAMHS needed to make greatest improvement in the short term. However they do not paint the whole picture. That is why there will be a need for further marked change if CAMHS is genuinely to be accessible to all children, families and carers, who need support.

The NSF is a ten-year development plan. Implementing such an ambitious programme of service improvement will require a sustained and concerted effort by commissioners and providers of CAMHS. This section of the report discusses the extent of progress which CAMHS should expect to achieve by the mid-point in the NSF cycle – that is, by 2009 - in order to achieve the full programme. The discussion deals in turn with the issues across the range of settings in which services are delivered, from the help given by non-specialist staff to the most specialist services including in-patient units.

### Partnership Working

The NSF and Every Child Matters stress the importance of developing partnerships between all agencies, recognising the challenges involved<sup>9</sup>. The NSF identified a range of areas as requiring multi-agency working, including but not exclusively, children in care, youth justice services, paediatric liaison, early intervention for psychosis, highly complex and challenging young people and services for black and minority ethnic groups.

Parents whose children have mental health disorders seek help from a variety of professionals and often from more than one service. Professionals most commonly approached are<sup>10</sup>:

- Teachers (40 per cent);
- Primary health care professionals (30 per cent);
- Specialist educational professionals, such as educational psychologists (25 per cent);
- Specialist CAMHS (25 per cent), who are seeing the most impaired young people (those with more than one diagnosis);
- Paediatrics (13 per cent);
- Social Services (13 per cent).

The range of professionals and services who are approached for help demonstrates the need for good links between agencies. If children, parents and carers are to receive the help that they need, it is important that staff have received the appropriate training to understand each others' respective roles and the support that can be provided by partner agencies.

Failure to take a child and family-centred approach may make parents, carers, children and young people feel stigmatised and lead to difficulties in engaging with services. The follow-up survey (ONS 2003) showed 29 per cent of parents whose children had a mental health problem had hesitated to seek help because they feared being blamed or seen as a failure.

## **Delivering Good Practice**

- Clear and strong leadership is provided to develop and deliver a CAMHS Strategy;
- Service redesign processes ensure that services are fit-for-purpose and reflect the need to support staff during the period of change management;
- Multi-agency services are co-located;
- Staff have a clear understanding of their different roles and expertise;
- Management structures are clarified and recognise agencies' differing working practices;
- Services train together and build teams;
- All levels of the service are committed to joint working

### Early Intervention and Primary Care

The Children's NSF embraced the importance of the early years for creating the foundation for building children's emotional, social, cognitive, physical development and well-being, and recognised the crucial role played by secure attachment with parents/carers as a cornerstone. The NSF recommendations are a blueprint for comprehensive multi-agency, multi-disciplinary parenting services, available across the spectrum of need and across the age range of the children from pre-birth onwards.

There have been a range of programmes developed in recent years of which the best known is Sure Start<sup>11</sup>. Other guidance for practitioners from the DfES relating to the early years has now been brought together in the Early Years Foundation Stage materials<sup>12</sup> and emotional development is one of the core outcomes against which all children are assessed at the end of the Foundation Stage.

#### **NSF Marker of Good Practice**

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.

Support for emotional well-being and relevant skills development among practitioners is also extending across other sectors. Complementing guidance already available to schools via the Healthy Schools Programme, a major development is the current national roll-out across primary schools of the Social and Emotional Aspects of Learning (SEAL) materials. Piloting of similar materials is underway in secondary schools, while more specialised training and accreditation opportunities are now being made available for some 500 school staff who have particular responsibility for youngsters with more complex behavioural, emotional and social difficulties. For older age groups, a new action programme on mental health support across the FE sector is now being finalised, while the new multi-agency developments linked to Every Child Matters reforms – Children's Centres,

Extended Schools, Targeted Youth Support, are all providing important new opportunities for improved multi-agency working and better emotional support for children and their families.

These developments show significant progress is being made across our front-line settings but there is still a great deal to do to ensure all front-line professionals have the skills and access to more specialist support they need. The importance of specialist CAMHS continuing to expand its support for this, including via new settings such as Children's Centres and Extended Schools, needs to be underlined.

### Delivering Good Practice

- Local agencies promote children's psychological well-being by delivering services which promote the mental health of mothers, particularly in the pre- and post-natal period. They address this within education, through support for parenting, especially for vulnerable groups, and through early years' and youth services.
- All agencies working together create a jointly commissioned and planned parenting service.
- Commissioners bring together education, social care, youth justice, CAMHS, AMH and the voluntary sector to create a parenting strategy and plan services, utilising evidence-based programmes, where appropriate.
- All front-line professionals in the children's workforce, including teachers, social workers and community health care staff, nurses and GPs are trained to promote children's mental health, to recognise problems as they are developing and to consult with and refer on to mental health professionals where necessary.
- Local Authorities and PCTs support schools and other settings to promote psychological well-being of children and young people, including as part of the Healthy Schools programme.
- Child mental health education is available on all pre- and post registration professional training courses and supplemented by in-house training provided locally according to assessed need.
- Recognition of child and adolescent mental health issues is part of the core training for all nurses, paediatricians, social workers and teachers.
- Approved Mental Health Professionals receive training on children's mental health, child protection and on the needs of children whose parents have mental illness.

- Local services inform parents, families and volunteers about mental health promotion using books and leaflets, CD ROMs, internet based programmes, telephone and e-mail based support and therapy programmes. These are promoted in schools, and Children's Centres.
- Primary Mental Health Workers (PMHWs) and other CAMHS staff link universal and secondary services and continue to develop and expand training for front-line workers, particularly within new settings such as Children's Centres and Extended Schools.

### Specialist CAMHS at Tiers 2 and 3

Specialist CAMHS are made up of trained professionals whose functions include the assessment and treatment of mental health problems as well as support, consultation and training for those working in the universal services, such as schools and primary healthcare, to promote psychological well-being. Specialist CAMH professionals work both individually alongside other primary care colleagues in the community, as well as in multi-disciplinary teams<sup>13</sup>. Most of the work is carried out in community settings, and in-patient facilities are used only in the most serious cases.

Commissioning specialist CAMHS can be challenging and complex. One factor contributing to the difficulty is that there is considerable developmental change throughout childhood and adolescence. Another factor is that some young people have transient mental health problems from which they may emerge without the need for outside intervention. But, in many cases, a delay in intervening will cause unnecessary distress to the young person and their parents or carers and may result in their condition deteriorating. Because of historically poor access to CAMHS, potential referrers may take no action at all or use alternative services or environments which, while more accessible may be poorer in terms of outcomes. There have for example been instances in the past of young people accommodated in bed-and-breakfast or Young Offender Institutions instead of receiving the CAMHS they need. As investment in CAMHS leads to improvements in quality and access, it is inevitable that more referrals will be made, reflecting increased satisfaction with, and expectations from, the service. Commissioners need to acknowledge this, and plan accordingly<sup>14</sup>.

More information on developing Tier 2 and 3 CAMHS can be found in the Workforce Development section on page 50.

### Progress on Access

There have been dramatic improvements in specialist CAMHS services between 2002 and 2005. More cases are being seen. 112,984 cases were seen in 2005 compared with 80,602 in 2002, an increase of 40 per cent. In 2005, 31,330 new cases were seen compared with 9,822 in 2002, an increase of 219 per cent. Children and families are also being seen sooner. In 2005, 52 per cent of new cases waited 4 weeks or less to see specialist CAMHS, whereas in 2002 only 44 per cent were seen within 4 weeks.

However, improvements still need to be made. Waiting times vary depending on the type of service being accessed and the location. At Tier 2-3, for example, 32 per cent of those waiting had waited for up to 3 months, a further 15 per cent had waited between 3 and 6 months, and a further 18 per cent had waited over six months. Almost all SHAs had some cases that fell into the longest wait category.

### Specialist CAMHS at Tier 4

Specialist CAMHS at Tier 4 need to have well-established links with all other aspects of CAMHS in order to provide the appropriate support for children, parents, carers and families. They include:

- Intensive community in-reach, outreach or home treatment services;
- Separate or designated age-appropriate in-patient psychiatric units for children and young people (since their developmental needs are different) including for those detained under the Mental Health Act 1983 and associated day-patient services;
- Specialist CAMH input into residential and secure social care units, specialist foster care and highly specialist educational units which deal with young people with complex, enduring and challenging behavioural and mental health problems. These teams may be able to deliver specialised therapies such as multi-dimensional foster care treatment and multi-systemic interventions.

- There is a continuing shortage of in-patient units. This results in young people being cared for:
- in adult psychiatric wards or paediatric wards which gives rise to concern about the appropriateness of the therapeutic environment; or
- outside their area of residence because of the lack of local provision. This disrupts family and social life and presents difficulties for the provision of mental health care when work with families is required.

Both the NSF and NICE<sup>15</sup> recommend that children and young people requiring admission or residential care should be cared for as close to home as possible. Commissioners and providers need to be able to reconcile this objective with the need to ensure that the team on any one site is large enough to be operationally viable and have sufficient expertise.

The Mental Health Act Commission (MHAC) has raised concerns about the treatment of young people within adult mental health facilities<sup>16</sup>. The MHAC found that among those detained under the Mental Health Act 1983, 82 per cent of young people aged 16/17 and 25 per cent of children under 16 were placed on adult wards.

Data collected by the Department of Health show that in 2005/6:

- 141,661 bed days were spent by children and adolescents on specialist CAMHS wards,
- 29,306 bed days were spent by 16/17 year olds on adult wards, and
- 353 bed days were spent by under-16s on adult wards.

### CAMHS Bed Provision

Data collected by the Royal College of Psychiatrists Research Unit show that:

- In 2006, there were 91 units with 1128 beds compared with 1999, when there were 72 units with 844 beds (26 per cent increase).
- The number of NHS beds has increased by 14 per cent from 632 to 721; the Independent sector beds have increased by 92 per cent from 212 to 407.
- The proportion of bed increases has been most significant in the Forensic Secure NHS Units: from 16 in 1999 to 68 in 2006 (325 per cent), and the Secure Independent Units from 56 in 1999 to 115 in 2006 (105 per cent).
- Eating disorder beds have increased from 73 in 1999 to 113 in 2006 (55 per cent) of which 93 are in the Independent sector.
- General beds have increased from 620 in 1999 to 739 in 2006 (19 per cent)
- of which 570 are in the NHS (4 per cent increase), and 169 are in the Independent sector (138 per cent increase).
- Looking at the age ranges served by these beds, the number of beds for adolescents rose from 459 in 1999 to 625 in 2006, an increase of 36 per cent. However, there was a reduction in the number of beds for children from 123 in 1999 to 86 in 2006, a drop of 30 per cent.
- The total general beds per million population varies from 9.1 in Yorkshire/Humber to 28.6 in London with an average of 15 in England.

### CAMHS Mapping data:

	2003	2004	2005	Diff. 04 -05	%	Diff. 03 -05	%
<b>Number of units</b>	122	114	113	-1	-1	-9	-7
<b>Staffing WTE</b>	2082	2176	2312	136	6	230	11
<b>Inpatient available beds</b>	N/A	569	621	52	9	-	-
<b>Inpatient commissioned beds</b>	651	665	680	15	2	29	4
<b>Day places</b>	277	457	478	21	5	201	73
<b>Intensive home support places</b>	788	734	747	13	2	-41	-5
<b>Intensive foster care placements</b>	15	51	64	13	25	49	327

The disparity between the mapping data and the Royal College of Psychiatrists Research Unit may be attributed to the time lag between the two data collections and different definitions of bed availability. The key issues that arise from both sets of data are that the distribution of beds across England remains inequitable although there has been an increase in beds for young people; that the increase in numbers of beds derives significantly from expansion of the independent sector; there has been a decrease in children's beds and an increase in specialist beds.

Recent developments of in-patient provision have focused on young people, but in-patient care may also be the best alternative for younger children when alternative provision in the community or home treatment services cannot meet their needs. The Children & Young Person's In-patient Evaluation (CHYPIE) study<sup>17</sup> of in-patient care for 8-18 year olds suggested that in-patient care is effective for the group of children and young people with a very severe level of disorder, complexity and functional impairment. Inpatient units offer multi-faceted interventions by highly skilled staff, as well as removing the young person temporarily from what is frequently an aversive environment. This meets their needs to a much greater extent than is usually possible in the community. The children and young people, across the whole age range, showed considerable

change which was clinically significant. The family work led to an improvement in family relationships on discharge and the change was sustained into a one year follow up. There was no evidence for children and young people becoming institutionalised as a result of inpatient care.

### **NSF Marker of Good Practice**

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.

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 the use of the 'care programme approach'.

### **Delivering Good Practice**

- CAMH Tier 4 services are closely linked with community and outreach services that extend to 16/17 year olds.
- CAMH Tier 4 services have adequate numbers of beds both for adolescents and for the smaller number of younger children who require in-patient treatment.
- The hospital environment, staffing levels and training are capable of meeting the needs of emergency admissions and challenging individuals.
- Services and the environment are appropriate to the needs of older adolescents.
- Specialist commissioning arrangements are in place to ensure appropriate levels of service provision.
- No children under 16 are admitted to adult wards.

- All older adolescents requiring in-patient treatment are admitted to a specialist CAMHS unit unless for reasons of maturity and independence they prefer to be admitted to a ward specialising in treating young adults.
- Independent and NHS services work closely together to ensure appropriate admission, liaison concerning progress and robust discharge planning to meet the needs of young people.
- Commissioners ensure service level agreements with CAMH Tier4 providers address the necessary level of detail to obtain agreed standards of provision.

The elimination of the unacceptable use of adult wards will take time to allow commissioners and providers to plan and develop alternative services. This should be possible within a five year period. In the interim, Mental Health Trusts and independent sector providers which are admitting children and adolescents to adult wards, and commissioners which purchase such placements, must have measures in place which ensure that they are meeting their statutory obligations towards children and adolescents and their safeguarding requirements. Key concerns are that:

- The beds have been specifically set aside for such use and are single sex;
- The staff are Criminal Record Bureau (CRB) checked and have support and training available to them from child mental health professionals;
- The Local Safeguarding Children Board is satisfied with the measures in place;
- Adult mental health staff and CAMHS work closely together to plan the care, discharge and after-care, utilising the Care Programme Approach;
- Education, recreational facilities and advocacy services are available to children and young people. Advocates are trained to work with children and young people and in mental health legislation; and
- Local authority and voluntary social care, vocational and housing services are part of the network supporting the young people.

### **Commissioning Specialist CAMHS at Tier4**

There has been insufficient planned commissioning of child and adolescent psychiatric in-patient units with undue reliance on spot-purchasing of individual beds. This has not given providers an adequate basis on which to plan services, and hinders the establishment of strong links between in-patient and community services which are needed to ensure continuity of care on admission and discharge and important in ensuring good outcomes for children and their families.

The new approach to commissioning specialised services, published in response to the Carter review, is set out in Appendix B of Health Reform in England: Update and Commissioning Framework<sup>18</sup>.

### **Paediatric Liaison**

CAMHS Paediatric Liaison (CAMHS-PL) is concerned with providing a bridge between acute paediatrics and psychiatric and psychosocial care. This is an essential service for the ill child, siblings, parents and carers in cases where the presenting illness has a psychological component, or where psychological distress is caused as a result of the illness.

Too often CAMHS-PL have insecure funding, with no local champions and are therefore vulnerable. However in London for example, virtually all CAMHS offer some out-patient referral, consultation and emergency service to their local paediatric service, though not necessarily a dedicated PL service.

#### **NSF Marker of Good Practice**

It is essential for a hospital with a children's service to ensure that staff have an understanding of how to assess and address the emotional wellbeing of children, and are able to identify significant mental health problems, and that there are robust liaison arrangements in place to secure CAMHS input, including psychiatry, psychology, individual and family psychotherapy, social work and CAMHS trained nurses<sup>19</sup>.

## Delivering Good Practice

- Whether CAMHS is provided by the same trust as paediatric services or by a different organisation, the professionals in both teams work together in an integrated way to support children and families and promote their mental health.
- Commissioners ensure that such links exist, and that where CAMHS and paediatric services are commissioned by different teams, all relevant commissioners collaborate in respect of paediatric liaison and in apportioning the cost to the various budgets.
- The paediatric liaison team is multi-disciplinary, providing both direct and indirect clinical work, staff consultation and support.
- Generic assessment and management of psychiatric problems, both full and sub-syndromal disorders are available.
- Training for CAMHS and paediatric staff is provided.
- Expertise in psychological management, psychopharmacology and social management including child protection is available.
- Liaison arrangements are made for the management of A&E services including deliberate self harm and acute psychiatric presentations; child protection; Neonatal Intensive Care Unit (NICU) and Paediatric Intensive Care Unit (PICU) and for complex, impairing, life threatening and long-term illness.
- The team is situated within the paediatric unit to allow easy and prompt referral and access.

### **Services for children and young people with complex, severe and persistent behavioural and mental health needs**

For children and young people with complex, severe and persistent problems, appropriate, accessible help is needed, which minimises disruption to their lives and those of their parents, carers and families. It should avoid, whenever possible, admission to psychiatric in-patient units and residential care.

Multi-disciplinary CAMH professionals working in the community, together with their multi-agency partners, have developed intensive, wrap-around therapeutic care services to address these needs. To achieve this requires sustained, multi-agency commissioning and commitment. Where residential provision is needed, the contribution of all agencies remains essential. All these children and young people are likely to have a combination of health, social care and educational needs. They should not be disadvantaged by disagreements between responsible agencies.

#### **NSF Marker of Good Practice**

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.

#### **Delivering Good Practice**

- Highly specialist multi-agency CAMHS services, which are able to support children and young people with complex needs in the community, are commissioned by groups of PCTs acting together in specialist commissioning arrangements with Local Authority partners.
- Multi-agency commissioning strategies and service planning are developed.
- Placement panels, protocols and pathways to address the needs of this group are developed within a multi-agency planning group.

## Services for Children in Care<sup>20</sup>

The factors which lead to a child entering care tend to be the same factors which can lead to mental health problems. As a group, children in care have a higher need for mental health services than their peers<sup>21</sup>. The overall rate of diagnosable mental health disorder in children in care up to 17 years in England was found to be 45%. 37% had clinically significant conduct disorders; 12% were assessed as having emotional disorders – anxiety and depression – and 7% were rated as hyperactive.

Progress has been made in providing appropriate, accessible CAMHS for Children in Care and their carers but further work is needed to ensure that this progress is maintained and extended. CAMHS Mapping shows that CAMHS Children in Care Teams have increased by 19 per cent (62-74) since 2004. There has also been an increase of 15 per cent in the number of Children in Care cases seen, which represents an increase in the total caseload of 0.6 per cent from 2004 to 2005. There has been progress in the provision of CAMHS input, and the self-assessment matrices show targeted services for children in care teams obtaining a higher than average score for progress across the country.

### **NSF Marker of Good Practice**

Primary Care Trusts and Local Authorities ensure that local needs assessments identify ... looked after children ... and that services are in place to meet their needs.

### Delivering Good Practice

- Social Services, Education, the NHS, YOTs, Housing, and voluntary organisations work closely together to meet the social care, educational and mental health needs of children in care.
- Dedicated, multi-disciplinary specialist CAMHS teams linked to generic CAMHS provide mental health assessment, treatment, consultation and support to children, young people, their families, carers and other professionals.
- Opportunities for early assessment and intervention are available.
- Arrangements exist for fast-tracking back to a familiar service and/or professional if further problems arise or additional help is needed.
- The assessment of special educational needs and provision of appropriate learning support is given priority by Education services.
- Priority is given to assessing the mental health needs of children in care at times when key decisions need to be made for their future.
- Individuals' needs for long-term therapeutic intervention and continuity of professional care, which may continue into adulthood, are met through multi-agency planning and provision.
- Evidence-based interventions, for example, Cognitive Behavioural Therapy (CBT) for Post Traumatic Stress Disorder (PTSD), and parent-management programmes for parents and carers are available.
- PMHWs or other CAMHS professionals working in the community develop training for foster and kinship carers, residential workers and other primary care professionals in working with looked-after children.
- Highly specialist services for young people with very complex needs, such as Multi-dimensional Treatment Foster Care are sustained through regional LA and Health commissioning.

## Youth Justice

Young offenders are a group with significant mental health needs<sup>22</sup>. Improving collaboration between CAMHS and the Youth Justice Board (YJB) means that 79.5 per cent of young offenders with acute needs were assessed within 15 days in 2003/04, and in 2004/05 this figure rose above 90 per cent.

CAMHS and the YJB are working together in a number of ways:

- Joint appointments between CAMHS and Youth Offending Teams (YOTs);
- Teams providing in-reach to secure units and Youth Offender Institutions (YOIs);
- Training and consultation by forensic nurses to professionals in residential, prison and community settings;
- Many health workers and especially CAMHS workers in YOTs have developed close links and protocols with specialist CAMHS.

An unpublished survey of Youth Offending Teams by the Mental Health Unit of NACRO, the crime reduction charity<sup>23</sup>, found that:

- 93 per cent of young offenders have a health worker of whom:
- 74 per cent have a mental health background
- 56 per cent are attached to CAMHS
- 80 per cent receive mental health supervision
- 69 per cent of YOTs have written protocols with CAMHS
- 96 per cent of YOTs are able to access mental health services for their clients

The engagement of young people with CAMHS after referral varied widely from 0 to 90 per cent not attending, with a mean of 38 per cent not attending.

- Protocols were seen as having positive effects on access, provision, and understanding of mental health in the YOT.
- Partnerships with CAMHS were seen as fruitful and effective.

The provision of secure forensic mental health units for adolescents has been expanded. In 2001 there were two units with a total of 28 beds in Manchester and Newcastle-upon-Tyne. The National Specialist Commissioning Advisory Group has ensured greater capacity and better geographical distribution with units opening in Birmingham, South London and West London. Another unit in Southampton in 2008 will bring the total to six units (88 beds).

These units also need to provide for the education of these adolescents, many of whom have had very disrupted schooling. The Learning and Skills Council is funding their education through hospital schools or colleges of further education.

### **Delivering Good Practice**

- Following assessment, all young offenders receive effective therapeutic interventions, where appropriate.

### **NSF Marker of Good Practice**

Specialist CAMHS at Tier 4 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.

- There is equity of access to CAMHS for young offenders in all secure settings – Young Offender Institutions, Secure Training Centres and Local Authority Secure Children's Homes.
- Improved links between services within secure settings and community services enable programmes of treatment which commence within a secure setting to continue after release and be completed in line with the guidance in Resettlement – key elements of effective practice published by the YJB in 2003<sup>22</sup>.

## Routine Outcome Monitoring (ROM)

Routine outcome monitoring is a crucial element of ensuring that clinical practice is founded on a strong evidence base, and that commissioning promotes positive outcomes for children and families. ROM is highly complex for CAMHS owing to the many factors involved in the mental health treatment of children. Nevertheless it is clear that commissioners and providers should be seeking to develop ROM.

### NSF Marker of Good Practice

All services routinely audit and evaluate their work.

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

Outcome monitoring is being supported by the work of 70 services in the CAMHS Outcome Research Consortium (CORC)<sup>25</sup>. They are collaborating to agree an approach whereby services will be able to monitor the effectiveness of their work, with some confidence in the tools they are using and in which the users feel able to participate to a level that makes the process meaningful. Priorities are to validate the tools used for the assessment of mental health and to increase the proportion of participating service users.

CORC is developing a model of outcome evaluation and analyses the results collaboratively to allow services to reflect on and improve their practice. CORC currently recommends three outcome measures – the Strengths and Difficulties Questionnaire (SDQ) (given to parents and children over the age of 11), the Child Global Assessment Scale (completed by practitioners) and the Experience of Service Questionnaire (CHI - ESQ) (given to children over 9 and their parents) . Many services also use the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), which may be most appropriate for young people in inpatient care and with more severe difficulties. The consortium is also exploring measures to capture the outcomes of consultations, qualitative measures, and measures based on service users' own-defined goals. Pseudonymised data are sent

to the CORC central team, who collate the results, both for the service as a whole and for individual teams, and present them to the service, alongside outcome data for CORC services as a whole and other national and community data. The CORC report indicates where the data collected are strong enough to allow accurate analysis and interpretation of the data. It analyses the data to compare with national trends and other relevant data, but services are encouraged to interpret these analyses in the light of their local context.

A survey in 2004-5 (Johnston C. & Gowers S.G., 2005<sup>26</sup>) to which 186 services responded showed that 86.6% regularly used quantitative clinical measures, but only 28.5% routinely used a system of routine outcome measurement with all clients. The most commonly used measures were the SDQ, Conners rating scales for ADHD and HoNOSCA. A survey<sup>27</sup> amongst new CORC members found many similarities with this study but also noted that 30 per cent of members were sharing information with key stakeholders, including commissioners and clinicians and in some cases service users. (Ford et al 2006). Both studies highlight constraints, including resource shortages, the continuing need to ensure validity of measures, and the challenge of gaining satisfactory response rates from parents and young people.

### **Developing Good Practice**

- Services are able to use data from ROM to inform commissioners, managers, teams, clinicians and users about their outcomes in the interests of service improvement.
- Commissioners support services to demonstrate their effectiveness by ensuring that services are adequately resourced to carry out ROM.
- Support is available for further development of ROM.

## Evidence-Based Practice

It is important that the results of Routine Outcome Monitoring, and information from research, are applied in the practical planning and delivery of services.

### NSF Marker of Good Practice

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.

In planning and delivering evidence-based practice, it is important to take account of guidance produced by the National Institute for Health and Clinical Excellence (NICE). NICE guidance for CAMHS now covers (date of guidance in brackets):

- Eating Disorders (2004);
- Self Harm (2004);
- Depression in children and young people (2005);
- Obsessive-Compulsive Disorder (OCD) (2005);
- Post-Traumatic Stress Disorder (PTSD) in adults and children (2005);
- Technology Appraisal of parent training/ education programmes in the management of children with Conduct Disorders (2006): and
- Attention-Deficit-Hyperactivity Disorder (ADHD) Technology Appraisal (2006).

There is an emphasis on the use of Cognitive Behavioural Therapy in several of these guidelines. It is important that the full range of evidence-based, psychotherapeutic interventions for child and adolescent mental health disorders are available (including Family Therapy, Child Psychotherapy and other validated approaches), that CAMHS professionals are trained to deliver them, and that CAMHS are commissioned to provide them.

### Delivering Good Practice

- Local service planners take a strategic overview so that CAMHS is able to offer a coordinated response to the totality of NICE guidance.
- Clinicians ensure that services maintain the flexibility to respond to the individual case and situation.
- Cognitive Behavioural Therapy (CBT) is used for the treatment of eating disorders, PTSD, OCD and depression, alongside a range of other interventions as appropriate, and is the basis for parent training programmes.

There are different levels of CBT expertise: those with specialist post-graduate training who use CBT with complex, chronic and co-morbid conditions; specialist CAMH professionals, who are able to use disorder-based standardised programmes; and non-specialist staff using a standardised CBT intervention, for example, in schools, with mild to moderate problems. It is also important that primary care staff, who would not be expected to use CBT, are aware of its value for some children and young people.

### Training

National training needs for CBT have been audited (ACAMH 2006) from which it can be seen that:

- More specialist child focused CBT training courses need to be established in order to equip staff with the necessary skills.
- Specialist CBT supervision needs to be established to ensure that the skills are being used appropriately and to provide further training.

A set of core courses could be developed by 4 or 5 Higher Education Institutions to address these issues on a nationwide basis, with training externally accredited via the BABCP (British Association of Behavioural and Cognitive Psychotherapy). In order to ensure that trained staff have appropriate support to use their skills, local post-training supervision groups should be established.

## Information Systems

The collection and availability of robust data is a pre-requisite for the creation of accurate and relevant care records and for the provision of a high-quality service. Such data enable services to manage individual children including ensuring child protection issues are adequately addressed, and to monitor activity, performance and outcomes.

### Progress

A care record for CAMHS, the “National CAMHS Dataset (NCDS)” was published in 2004. It was disseminated via the National CAMHS Support Service. In 2006, a “Do Once And Share project” (DOAS) was sponsored by Connecting for Health to advise on a care record for CAMH services. Following consultation with CAMHS stakeholders, an amended version of the NCDS was produced that covered the key elements of data needed by services to ensure they could function in a multi-agency environment. This is available via the NCSS website.

The DH Child Health Information Strategy is in the process of agreeing a “secondary purposes” dataset for CAMHS, due for completion in late 2007. This dataset will define standard specifications of data extracts from clinical records. When implemented, the dataset will support a range of ‘secondary uses’ functions such as commissioning, clinical audit, research, planning and performance management. The dataset will build upon existing data collections and seek to avoid placing additional burdens on services. The dataset will be compatible with the NHS Care Record.

The Common Assessment Framework (CAF) is a standard approach to conducting an assessment of the needs of a child or young person and deciding how they should be met. It has been developed for use by all people working with children and young people so that they can communicate better and work more effectively together. It supports earlier intervention by providing a tool to enable practitioners in universal, as well as targeted or specialist services, to assess needs at an early stage. It aims to be the main method for early assessment by practitioners, reducing the scale of specialist assessments, and avoiding the need to ask for the

same information each time an assessment takes place. By sharing information between agencies with the consent of the child or their parent CAF helps to reduce time spent on repeated assessments and thereby helps services to be timely and coordinated. CAF was piloted in 2005 and national roll-out began in April 2006.

Information Sharing Index. The Government is developing the information sharing index which will cover all children in England and will be available in all local authority areas by the end of 2008. The index is a simple tool to allow practitioners working with a child to see who else is involved and provide contact details so that they can share relevant information about children who need services or about whose welfare they are concerned. However, so as not to deter the take up of sensitive services - sexual health, mental health (including CAMHS tiers 2, 3 and 4) and substance abuse - contact information about practitioners providing sensitive services will require explicit consent. If consent is gained the index will only indicate that an unspecified service is being provided. There will be the ability to over-ride this where a child is suffering or is likely to suffer, significant harm.

### **Developing Good Practice**

- Services are able to collect data about their activity to allow them to run safely and effectively.
- Services are able to collect data about their activity to allow them to audit their work and reflect upon the outcomes of their activity.
- Data are able to be collated and compared to allow appropriate national reports and audit.
- Support is available for the further development and refinement of datasets and databases within CAMHS.

## Delivering Race Equality

Children and families from all ethnic and religious backgrounds should be able to access CAMHS which are culturally sensitive, and this is as much a part of ensuring a comprehensive CAMHS as the capacity to treat different conditions and ages. While there are examples of good practice among some providers, there is still some distance to go before CAMHS meet the needs of all groups in the community.

### NSF Marker of Good Practice

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

In developing culturally sensitive services for black and minority ethnic groups, CAMHS need to have regard to the way in which services are delivered, staff training, recruitment of professionals from ethnic minorities and the provision of interpreters. There are many areas of the country where services have developed good models of working with children and young people from minority ethnic groups.

The concept of cultural sensitivity applies to the whole community. In order to deliver services that recognise the needs of both the majority and minorities in the population, clinicians have to be trained from the outset to consider the question of how to deliver services in a culturally appropriate way, at all times.

Commissioners and providers must ensure that they are meeting their statutory duties under the Race Relations (Amendment) Act 2000 especially with regard to promoting equality of opportunity and eliminating discrimination. Needs assessments and action research can help commissioners to develop culturally appropriate access points and inform the provision of services.

CAMHS should now be using the Delivering Race Equality in Mental Healthcare (DRE) action plan as their central guide for reforming their strategic planning,

commissioning, and delivery mechanisms to address inequality, and exclusion for BME young people and their families. At the heart of the approach are three building blocks that will drive this major change programme:

- Appropriate and responsive services
- Engaged communities
- Better information

Implementing all the actions within DRE will positively impact on improving access, experience and outcomes for BME young people and their families.

Central to this challenging programme of change is the new workforce role of BME Community Development Worker (BME CDW). They will support communities, build capacity, and ensure that the community views are represented within services.

The Mental Health Act Commission (MHAC) study (2004) found 26.8 per cent of the young people detained on adult wards were from ethnic minorities. While Black African and Caribbeans make up only 2.9 per cent of the youth population, they accounted for 13.1 per cent of the young people detained on adult wards.

The CAMHS mapping for 2005 shows that access for black youth is improving. The Tier 4 caseload totalled 5,123 over 6 months and that of these (and excluding cases where the ethnicity was not stated), 6 per cent were black young people, an increase of nearly 1.5 per cent since 2004. In Tier 4 services the number of black young people in the service in the sample period of one month were 254 in 2005, an increase of 59 (30 per cent) on the 195 in 2004.

In specialist CAMHS at Tiers 2-3, the number of black young people in the service in the sample period was 3,927 in 2005, an increase of 988 (34 per cent) on the 2,939 in 2004. Looking at the caseload of specialist CAMHS at Tiers 2-3 as a whole (and excluding cases where the ethnicity was not stated), the number of black young people rose from a 3.5 per cent share of the caseload in 2004 to 4.0 per cent in 2005.

## **Delivering Good Practice**

- Local audits to monitor the ethnicity of under-18 users of in-patient services in adult and adolescent wards are carried out.
- Cultural sensitivity training is available for all staff to work effectively with families from black and minority ethnic groups within local communities.
- Services recruit and train professionals from their local ethnic minorities and ensure the provision and training of interpreters.
- Commissioners, statutory, independent and voluntary organisations work together to ensure that services for minority groups are clearly signposted and networked together.

### Workforce Development – Tiers 2-4

Modernising and strengthening the workforce is a central feature outlined in the National Service Framework for Children and applies to both specialist and universal services. There has been progress in the development of new roles and types of mental health workers within CAMHS, particularly roles for non-professionally-affiliated and unqualified workers. While the CAMHS workforce has expanded recently, recruitment is still needed to deliver the full range of NSF requirements.

The Royal College of Paediatrics and Child Health is planning a new consultant sub-specialty with special expertise in child mental health. This would make a significant positive contribution to the CAMH workforce.

The Chief Nursing Officer published *From values to action*, a review of Mental Health Nursing, in April 2006. This looks at services for all ages, and is relevant to CAMHS teams<sup>28</sup>.

### Progress on Workforce

There has been continued, but steady growth in all except CAMH Tier 4 services, with an increase in the number of generic teams by 30 (6 per cent), while staffing in generic teams increased by 589 WTE (11 per cent of total staff). Generic team staffing rose by 39 per cent between 2003 and 2005.

Targeted teams, for example those working with children in care, self harm, or substance misuse increased from 167 in 2003 to 267 in 2005 (60 per cent) and staffing increased by 454 WTE (56 per cent).

Dedicated CAMHS workers who work in non-CAMHS teams have also increased in number. The number of teams with these specialist workers has increased by 21 (16 per cent) between 2003 and 2005.

Numbers of Primary Mental Health Workers (PMHWs) have increased by 33 per cent, from 382 WTE in 2004 to 506 WTE in 2005.

There has been an expansion in Tier 2, working across Primary Health Care, Education, Social Care, Children in Care Services, Youth Offending Teams (YOTs) and Behaviour and Education Support Teams (BESTs) with a 53 per cent increase in staff in the category of 'other qualified therapists', which includes PMHWs. There has been a 19 per cent increase in LA Social Service CAMHS staffing.

However, the picture is characterised by wide variations between regions. In 2004, the number of clinical staff varied from 5.1 to 17.7 whole time equivalents per 100,000 total population and the average in 2005 is 11.7, ranging from 6.0 to 20.7 whole time equivalents per 100,000 total population.

Despite very significant advances in specialist services staffing, there is still dissatisfaction with access to CAMHS in many parts of the country. This is an indication of the extent of unmet need and the requirement for further increases in capacity.

Improvements in access and in the size of the workforce have been achieved both through increased investment and service redesign.

### **NSF Marker of Good Practice**

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.

Services are resourced to address variations in staff availability, fluctuations in demand, 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.

### Delivering Good Practice

- Commissioners and providers of services are working towards the recommendation in the NSF that there should be 15-20 WTE per 100,000 inhabitants. (Further details pages 28-29, Standard 9, NSF);
- Commissioners and providers of services are developing the skill mix, capability and competencies of their staff to deliver all the assessment and treatment components of comprehensive CAMHS, improve access and reduce waiting times;
- Commissioning and providing organisations root workforce design and planning in local service planning and delivery.
- Teams identify and use creative means to recruit and retain people in the workforce.
- Commissioners and providers promote new ways of working across professional boundaries.
- Services create new roles to tap into a new recruitment pool and so complement existing staff types.
- The workforce is developed through up-to-date education and training at both pre- and post-qualification levels.
- Managers are supported to develop leadership and change management skills

## Appropriate and Safe Settings for CAMHS

The location of services, the quality of the built environment and the nature of the decor and furnishings send very important signals to service users and the wider public about the commitment of statutory agencies to meeting mental health needs. They are also important in encouraging attendance at services, reducing stigmatisation and ensuring safety of service users.

### NSF Marker of Good Practice

Services are offered in appropriate, safe, child-centred surroundings with the necessary facilities to ensure optimum professional practice.

### Delivering Good Practice

- Commissioners conduct an audit of the built environment in which CAMHS are operating, including seeking the views of children, young people and their families about the conditions which they would like to see in their local services.
- A timetable for planned improvements, making use of capital which has been allocated for the purpose is in place
- Services are working in fit for purpose buildings in locations which offer good public transport access for patients.

## User Involvement

It is important for services to engage service users – parents/carers as well as children - and to use their feedback in planning and developing services. Services need to be able to respond to users' feedback so that they are planned with a view to improving the user's experience. Not all users will have the same viewpoint, so providers need to be able to tailor services to individuals' needs.

### NSF Marker of Good Practice

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

## Delivering Good Practice

- Statutory services develop partnerships with voluntary organisations to facilitate user involvement.
- Services appoint a professional with a brief to develop user involvement.
- Every CAMHS partnership should have a support network for service users and carers.

## Choice

Choice is integral to the development of more responsive NHS services, including CAMHS. Good clinical practice should build in choice at every level, particularly in relation to parents who will have a key role in decisions on their children's care. Where CAMHS capacity is low or where services are particularly specialised, it can be more challenging to offer choice to children, young people and families. In such circumstances commissioners and providers need to make an extra effort to maximise the extent to which choice is available throughout the care pathway.

## **NSF Marker of Good Practice**

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.

### **Delivering Good Practice**

- Both primary care referrers and specialist services make known the range of services, both statutory and voluntary, specialist and community, which may be appropriate for the needs of families, parents and young people, when considering referral.
- There is consideration of where and by whom the user and their families/carers would prefer to be seen.
- On referral to specialist CAMHS, a choice of appointment dates and times is offered.
- At assessment, the treatment alternatives and their advantages and disadvantages are clarified; advice is given, offering choice where appropriate.
- Where in-patient admission may be required, the use of alternatives such as home treatment or day services where available and appropriate, are explored.

## Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services

- <sup>1</sup> Nuffield Foundation (2004) Time trends in adolescent well-being  
[www.nuffieldfoundation.org/fileLibrary/pdf/2004\\_seminars\\_children\\_families\\_adolescents\\_and\\_wellbeing001.pdf](http://www.nuffieldfoundation.org/fileLibrary/pdf/2004_seminars_children_families_adolescents_and_wellbeing001.pdf) & Collishaw S., Maughan B., Goodman R., Pickles A. (2004). Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry*, 45 (8), 1350-1362.
- <sup>2</sup> Office for National Statistics (2005) Mental Health in children and young people in Great Britain, 2004  
[www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT\\_ID=4118332&chk=0JUjTo](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4118332&chk=0JUjTo)
- <sup>3</sup>  
[www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT\\_ID=4089111&chk=U8Ecln](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln)
- <sup>4</sup> The definition of a comprehensive CAMHS was first published in the NSF Emerging Findings in May 2003 and confirmed in the NSF (pages 48-52)
- <sup>5</sup> [www.hascas.org.uk/index.htm](http://www.hascas.org.uk/index.htm)
- <sup>6</sup> [www.camhsmapping.org.uk](http://www.camhsmapping.org.uk)
- <sup>7</sup> staffing defined as specialist CAMHS at Tiers 2-4 plus admin and management
- <sup>8</sup> Ford T, Hamilton H, Meltzer H & Goodman R. (accepted December 2005). Child mental health is everybody's business; the prevalence of contacts with public sectors services by the types of disorder among British school children in a three-year period. *Child and Adolescent Mental Health*
- <sup>9</sup> Further guidance on partnership working will be contained in the Local Government White Paper due for publication towards the end of 2006.
- <sup>10</sup> Ford T, Hamilton H, Meltzer H & Goodman R. (accepted December 2005). Child mental health is everybody's business; the prevalence of contacts with public sectors services by the types of disorder among British school children in a three-year period. *Child and Adolescent Mental Health*.
- <sup>9</sup> Revised Sure Start guidance for Children's Centres on training staff to support parents with mental health problems and promote their social inclusion is due to be published by the end of 2006.
- <sup>10</sup> Currently being finalised following a consultation, and due to be published definitively by the end of 2006.
- <sup>13</sup> In Youth Matters, Next Steps DfES set out proposals for ensuring that services, including mental health services, are coordinated across traditional boundaries to help meet individuals' personal needs and circumstances.
- <sup>14</sup> Further guidance will be found in the Commissioning Framework for Health and Well-being which the Department of Health is planning to publish at the end of 2006 and the Commissioning Guide to CAMHS planned for 2007.
- <sup>15</sup> In their guideline for children and young people with depression
- <sup>16</sup> [www.mhac.org.uk/Pages/documents/publications/children%20%20mionors%20report.pdf](http://www.mhac.org.uk/Pages/documents/publications/children%20%20mionors%20report.pdf)
- <sup>17</sup> Jacobs, B., Green, J., Kroll, L., et al (2004) Two and half thousand hours. The Children and Young Persons Inpatient Evaluation Study (CHYPIE) into process and outcome of inpatient child and adolescent psychiatric care Report for the Department of Health, 2004
- <sup>18</sup> [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/CommissioningSpecialisedArticle/fs/en?CONTENT\\_ID=4135174&chk=H2g0oV](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/Commissioning/CommissioningSpecialisedServices/CommissioningSpecialisedArticle/fs/en?CONTENT_ID=4135174&chk=H2g0oV)
- <sup>19</sup> From Standard 7 of the Children's NSF: Hospital Services
- <sup>20</sup> A Green Paper on Services for Children in care was published by DfES in October 2006 and discusses the needs of this group in greater detail.
- <sup>21</sup> The mental health of young people looked after by local authorities in England, ONS 2003

[http://www.statistics.gov.uk/downloads/theme\\_health/ChildrensMentalHlth.pdf](http://www.statistics.gov.uk/downloads/theme_health/ChildrensMentalHlth.pdf)

<sup>22</sup>[www.youth-justice-board.gov.uk/Publications/Scripts/prodView.asp?idproduct=255&eP=PP](http://www.youth-justice-board.gov.uk/Publications/Scripts/prodView.asp?idproduct=255&eP=PP)

<sup>23</sup>Unpublished NACRO report 'The Role of the YOT Health Specialist: Identifying and Sharing Good Practice' (Working Title)

<sup>24</sup>[www.youth-justice-board.gov.uk/cgi-](http://www.youth-justice-board.gov.uk/cgi-bin/MsmGo.exe?grab_id=567&page_id=5243648&query=resettlement&hiword=RESETTLE+RESETTLING+resettlement+)

[bin/MsmGo.exe?grab\\_id=567&page\\_id=5243648&query=resettlement&hiword=RESETTLE+RESETTLING+resettlement+](http://www.youth-justice-board.gov.uk/cgi-bin/MsmGo.exe?grab_id=567&page_id=5243648&query=resettlement&hiword=RESETTLE+RESETTLING+resettlement+)

<sup>25</sup>[www.camhoutcomeresearch.org.uk](http://www.camhoutcomeresearch.org.uk)

<sup>26</sup>Johnston C. & Gowers S.G.,(2005) Routine Outcome Measurement: A survey of UK Child and Adolescent Mental Health Services. *Child & Adolescent Mental Health*. Vol 10, 3, 133-139.

<sup>27</sup>Ford, T., Tingay, K, Wolpert, M. & the CORC steering group (2006) CORC's survey of routine outcome monitoring and the National CAMHS Dataset Developments; A response to Johnson and Gower *Child & Adolescent Mental Health*. Vol 11, 1, 50-52

<sup>28</sup>[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4133839&chk=RJV7mg](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4133839&chk=RJV7mg)

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