

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**

**Annex:  
models of  
good practice**

*Change for Children - Every Child Matters*

<b>Policy</b>	Estates
HR/Workforce	Performance
Management	IM & T
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# 24 Hour and Emergency Cover

## Leeds (pop 800,000)

Out of Hours, weekends/bank holidays cover arrangements: a standard medical rota - Senior House Officers (SHOs) from child, Learning Disability (LD) and psychotherapy do first on call 1 in 7, and Consultants do second on call, with a Specialist Registrar (SpR) sometimes available between the SHO and consultant.

Weekday 9-5: there is a multidisciplinary Tier 3 duty clinician on call system (one day at a time) and a multidisciplinary self harm assessment rota. All self harm cases are admitted and assessed by the following day. Wards have to call a single point of contact in CAMHS before 10am for same day assessment. Consultant Child and Adolescent Psychiatrists are available (second on call) for discussion and to go out and do joint assessment if the first on call is worried.

Urgent referrals from community: each catchment area team has a designated duty clinician to deal with urgent calls, liaise and arrange an appropriate response - usually advice and sometimes a quick out patient appointment. Each team has an 'urgent assessment slot' once a week that the duty clinician can book a patient into.

Training for CAMHS staff consists of a training day twice a year for new staff and advanced training once a year for more experienced staff who have been on the rota for a minimum period.

Training for A&E staff is provided twice a year and is being revised to comply with NICE guidance.

# Services and transitional arrangements for young people

## Wirral Child and Family Service 16-19 Service

The 16-19 Team serves a population of 15,700 16-19 year olds. The referral rate has increased from 200 cases per year in 1997 when the service began, to 350 in 2005; 7-10 have psychosis. The team is embedded within CAMHS, to which it also provides in-service training. Locality CAMHS teams act on the 16-19 team's behalf in local agency relationships e.g. with GPs, school nurses and learning mentors.

Age boundaries are flexible, e.g. under-16 locality teams will finish their involvement over a few months even if a young person has reached 16. ADHD monitoring of medication continues from under 16 until 19. The team can refer to child psychotherapists, and to the CAMHS Educational Day Unit for 16-17 year olds when appropriate. There is a Sure Start Mellow Parenting Group for teenage mothers.

### Positive Outcomes

Increasing collaboration and joint education between CAMHS and Adult Mental Health Services has reduced inappropriate admissions, facilitated joint work for young people with psychosis with the Early Intervention in Psychosis (EIP) Team, and a quick response to emergencies. Most importantly, young people like the flexibility, accessibility and responsiveness of the service.

### Team Composition

1 Co-ordinator Therapist; 2.5 Community Psychiatric Nurses (CPN); 0.5 Consultant Clinical Psychologist; 0.8 Consultant Child and Adolescent Psychiatrist; 1 Social Worker.

### Associate Members

1 Registered Mental Nurse (RMN) with Drugs and Alcohol Action Team (DAAT) - also covers under 16 years but based with 16-19 team.

1 RMN with Youth Offending Service (YOS) - also covers under 16 years but based with 16-19 team.

0.2 sessions Child Psychiatry paid by Early Intervention in Psychosis.

0.5 sessions social worker to provide mental health input to leaving care and a transitional worker from CAMHS grant to provide more input to 16-19 year olds with ADHD or autistic spectrum disorders.

0.1 session RMN paid by Wirral Hospital Trust to provide psychological input to 16-19 year olds attending adult diabetic clinic.

## Joint Work

Social Services: social worker links child social service teams and adult teams; facilitates Mental Health Act work and accesses resources e.g. care packages.

Education: regular formal liaison with 6th Form College and Further Education College and 6th forms.

Learning Disability: joint assessments; learning disability has an adolescent support team.

Paediatrics: a paediatrician assesses 16 and 17 year olds regarding conditions such as epilepsy and acts as a bridge, if required, to adult neurology service.

Drug and Alcohol: DAAT (virtual team) RMN provides input to 16-19 year olds with drug and alcohol and mental health difficulties.

Youth Offending: RMN works with Youth Offending Service, involving 16-19 Team when required.

Forum Housing: advice and training for this voluntary organisation that provides accommodation to young people in this age range.

### **42nd Street**

42nd Street is a voluntary organisation based in Manchester, working closely with statutory agencies, helping to plan services, offering training and providing support to young people experiencing stress and mental health problems. It aims to offer choice, flexibility and help in the transition to adulthood. The Children and Young People's Team works with 16 and 17 year olds, from varied cultural backgrounds, using a variety of skills, offering a range of services, early intervention, drop-in services, advocacy and a helpline. It also works, alongside other agencies with young people who have more complex needs, helping to ensure that they receive help. Where appropriate the young people are supported to access adult services and are empowered to make choices for themselves in the adult world.

### **Resource**

Youth Access is a national membership organisation for 300 young people's information, advice, counselling and support services (YIACS), providing flexible help in informal settings ([www.youthaccess.org.uk](http://www.youthaccess.org.uk)). It supports the development of quality standards for YIACS and works to improve their links with statutory services. The 'Access to Counselling Project' is promoting stronger links between CAMHS and YIACS.

# Early Intervention for Psychosis Teams (EIP)

## Newcastle & North Tyneside Early Intervention in Psychosis Service

The aim was to create an EIP service that could meet the 'Policy Implementation Guidance' of serving those between the ages of 14-35. Team members had a background, skills and experience of working in adult mental health services, not CAMHS. Building on existing relations with CAMHS colleagues, the key support to the development work by Adult Psychiatry was provided by a senior nurse from CAMHS. Shared-care arrangements were agreed for the youngest people referred to the service. This necessitated complex working arrangements with CAMHS colleagues in a variety of teams across two Local Authorities and in two separate Trusts.

Following the establishment of the service in January 2004, the service has continued to work collaboratively with CAMHS clinicians and there have also been joint educational meetings. In addition to collaborative working, there has also been an active campaign to develop an EIP service with its own CAMHS capacity, a service that would not have to look outside to manage the youngest service users. This involved the recruitment of Care Co-ordinators and Support, Time and Recovery workers, with experience of working with young people, involving service users and carers in the process.

The team gained clinical experience, participated in joint CAMHS/AMHS educational and clinical meetings and developed a supportive network of statutory and non-statutory, youth-orientated bodies, including CAMHS professionals, carers and colleagues in higher education. From February 2006, the Trust facilitated the provision of two sessions of a CAMHS Consultant for the team. In addition to direct clinical work with adolescent onset psychosis, this has added a developmental perspective and helped improve the quality of care. It provides junior medical input, decreases anxiety of staff with less experience of working with young people and contributes to the culture of care within the team.

The adolescent psychiatrist is not simply responsible for under-19s, but contributes to care of older service users, who often have had difficulties, necessitating CAMHS involvement when they were younger.

This provision not only strengthens the existing team but makes the services more attractive to other staff and helps the team move forward, becoming not an adult service trying to look after young people, not a CAMHS EIP team but a hybrid, a specialist service for young people with early psychosis, freed from artificial age boundaries.

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

## Northumberland Tyne and Wear NHS Trust

The Trust, in conjunction with Northumberland Families and Children Trust, delivers a CAMH Service for children and adolescents with learning disabilities. The Child and Adolescent Community Learning Disability Team (CALDT)<sup>1</sup> provides mental health services to children with mild, moderate and severe learning disability, including those within the Autistic Spectrum and with other developmental disorders and mental health problems. This features:

- Partnership Working - CAMHS Learning Disability service managed by health, working towards the delivery of services within Childrens Trust framework and standards.
- Coordinated Service delivery
  - Agreed referral protocol between CAMHS & CAMHS LD;
  - Looking to agree Care Pathway on the model provided by recent Connecting for Health Do Once & Share Project
  - Ongoing development of seamless working with Children's Trust (Education / Social Services)
- A specialist Tier 3 service providing both mental health and also disability assessment and treatment to young people with all levels of intellectual disability.
- Sharing of competencies through joint training on common issues, training workshops for parents, consultation with school staff.
- Initiatives to share expertise and develop common approaches (e.g. clinical outcome measures, common Care Pathway for Depression, Prospective Audit).
- Preserving specialist competencies through a dedicated CAMHS-LD Team with common service standards.

The team comprises 7.2 Full Time Equivalent (FTE) nurses and 1.0 FTE support worker, 2.2 FTE qualified psychology, 18hrs occupational therapy and five sessions of consultant psychiatry support and treatment. Referrals for children with all degrees of learning disability including mild are accepted. Close links are maintained with mainstream schools and children's services, special needs and disability provision.

The multidisciplinary team has consultative and treatment roles: offering diagnosis and treatment of mental health problems, epilepsy management, behavioural work, sex education, family casework, anger management, social skills, play therapy, sensory assessment and others.

Close links across tiers are maintained with community paediatrics, school nurses, voluntary agencies and respite care facilities. Liaison with education staff is a priority. Psychiatric outpatient clinics are held, where appropriate, at special schools in order to gain a comprehensive assessment of the child's functioning in all settings as well as maintaining personal links with teaching staff and school nurses. Community nursing staff are co-located with the Social Services team for disabled children in three of their four office locations (in a large county area geographical spread is a feature of this team). Members of the team co-facilitate group work alongside, teachers, social workers and speech and language therapists (for example, group work on sex and social relationships).

Information sharing with parents and involved professionals is standard. The child's parents receive copies of letters, and often the child also receives letters in developmentally appropriate language. The team uses collaborative report writing: 'About Me' books are drafted from information provided by parents and other professionals and the final version agreed in a joint meeting with parents and professionals.

# CAMHS Management and Leadership

## North West Region

CAMHS Directors have made a considerable impact on service delivery and planning in many areas. There is a need to balance the operational and strategic management of a service.

In some services, this has been achieved by:

- CAMHS Coordinators and Clinical Service Managers: the locality/community based teams in the Wirral and Cheshire are led by multi-disciplinary professionals backed by Consultant Psychiatrists and Psychologists, and they ensure the accessibility of CAMHS, through consultation, and the management of referral flows through the system.
- CAMHS Strategy Posts (development manager or coordinator of partnership). Where these have been appointed, for example, in Lancashire by PCTs and Local Authorities, they have raised the profile of CAMHS and provided coordinated community training.

# Service Redesign

## Richmond and East Herts CAMHS

This service has made extensive changes using the 7 HELPFUL Habits<sup>2</sup> of Effective CAMHS and a clinical system called the Choice and Partnership Approach (CAPA) that incorporates many of the Habits. The HELPFUL Habits extend and incorporate many of the Ten High Impact Changes for Service Improvement and Delivery (Modernisation Agency, 2004) The Habits are:

- Handle demand.**
- Extend capacity.**
- Let go of families.**
- Process map and redesign.**
- Flow management.**
- Use Care Bundles.**
- Look after staff.**

The two outpatient teams struggled with waiting lists of nearly a year and increasing demand for services. Service redesign began in Richmond in 2000 following analysis of waiting list management (Process Map and Redesign). A team day provided a new service model of Partnership clinics (called Starter clinics), which was implemented and evaluated as a pilot over a three month period. The model was rolled out to the whole service in 2001. It incorporated a focused, strengths-based approach to clinical engagement and multidisciplinary work, care planning and regular reviews (Let Families Go).

Service cuts due to loss of funding and continued increased demand led to further service redesign, including extending clinical roles and skills, negotiation of a Service Level Agreement in 2003 and CAMHS Development Strategy (Extend Clinical Skills; Handle Demand). The clinical service model was further refined in 2003 to improve engagement, choice and demand management through initial Choice appointments (called Face2Face in Richmond). Partnership work was privileged with generic mini multidisciplinary groups of clinicians with extended clinical skills. A segmented clinic for young people with eating disorders was developed (Flow Management). A systematic approach to the management of these difficulties was agreed using a Care Bundle approach (Use Care Bundles).

Bimonthly team days to facilitate change management, annual appraisal and guidance on caseload activity were important components of the service model (Look After Staff).

In contrast to the slower change management approach of audit, redesign and piloting that occurred in Richmond, East Herts CAMHS moved from a traditional waiting list system in 2004 to CAPA over a 3-month period. The team managed to blitz a waiting list of over 200 families and introduce the new system through a careful project management plan, clinical leadership and team involvement in change. Extended clinical roles, generic strengths based work, care planning, capacity calculation, team job planning, and activity monitoring have been key to the success of the changes. All families are offered an initial Choice appointment followed by Partnership work in clinics by extended skills clinicians.

Formal user and clinical evaluation in East Herts. is confirming that CAPA is a model that works well for users, is satisfying for clinicians and ensures services meet many of the Standards for Health and all Choice Points in Our Choices in Mental Health. Effective use of capacity and clarity about the service enhances service development towards a comprehensive CAMHS.

The experience of change management, the 7 HELPFUL Habits and the clinical system CAPA is being replicated successfully in other teams. Training in the 7 HELPFUL Habits and CAPA has been delivered through a series of national and regional workshops through a secondment to the London Development Centre/ Care Service Improvement Partnership (CSIP) and is supported with a workbook and website [www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk).

# Early Intervention and Primary Care

## **Sure Start Middleton Family Centre (Leeds) 'Baby Bonding' Early Attachment Project**

### The Team

The project is co-ordinated by a consultant clinical child psychologist; health visitors, midwives and a nursery nurse are actively involved. The team has close links with other agencies including specialist CAMHS, LA social services and adult mental health services. Work is community-based with offices in the Sure Start/Children's Centre Family Centre which facilitates good access both geographically and with regard to stigmatization. Much of the work is completed during home visits.

### The Process

The project is introduced to women in the latter stages of pregnancy by the midwife handing out a special leaflet. The target population is all first time mothers in the area plus any women at risk of difficulties in their relationship with their infant due to mental health difficulties, personal histories of abuse and neglect etc. Therapeutic help can be offered to women at this stage and continued where necessary after delivery of the baby. Most often this is done by the clinical psychologist but referrals are made to local adult mental health services (counsellor, psychotherapist) as appropriate.

A booklet called Understanding Your Baby has been developed to support the work of the project and this is used by the health visitor to facilitate discussions at the time of the baby's birth. It assists families in 'reading' their baby's cues and communications, promoting good quality interactions. It has been positively evaluated by families who were also consulted during the preparation of the booklet.

Interactions between the infant and the main carer(s) are assessed and videoed when the infants are about six weeks old, using an evidence-based tool (NCAST) developed at the University of Washington, USA. NCAST enables a detailed assessment of the adult's and infant's interactions. Feedback is given using the videos. Advice and/or appropriate interventions are offered as necessary and reassessment using the NCAST tool allows change to be measured and progress monitored.

Families are seen again when infants are around 8 months old to check progress although many will be being seen regularly by members of the 'Baby Bonding' team or the wider Sure Start team.

At one year of age, the relationship between infant and primary carer is assessed using the Strange Situation assessment procedure which looks at the security of the child's attachment. Intervention and/or referral can be arranged at this point.

Preliminary findings are encouraging showing for example a greater proportion of children have secure attachments at one year of age than one would expect in this type of population and improvements in the quality of mother-infant interaction.

Training is provided for primary care professionals to use the booklet and some of these go onto further NCAST training.

## **Work Discussion Groups for Education Staff**

### **Brent Centre for Young People and Preston Manor High School, London**

Brent Centre for Young People (BCYP) is a voluntary organisation offering psychotherapy, drugs, alcohol and sexual health services to young people. Since 1998, BCYP has run a Mental Health Outreach Project at Preston Manor High School and several other schools in Brent. In addition to working with pupils, the project aims to support teachers through Work Discussion Groups, a model of training developed at the Tavistock Clinic. These groups provide teachers with an opportunity to think in depth about any concerns and difficulties in their work with pupils or class groups. These issues are discussed together, facilitated by a psychotherapist. The aims of the groups are to help staff:

- Develop understanding about the underlying meaning of pupil behaviour
- Develop understanding about psychological factors that impact on teaching and learning
- Manage the complexities of the pupil-teacher relationship; and
- Feel more confident about and supported in work with pupils

Similar projects have been developed within five other secondary schools in Brent. Evaluation with over 120 staff has shown that:

- 97 per cent were helped to persevere with challenging pupils when they felt like giving up
- 83 per cent reported feeling less stressed after talking about challenging pupils/class groups.

In Preston Manor High School alone, over a three year period, the school reported that 22 staff attending groups had a significantly lower rate of absence than the whole staff group. The cost for a project running half a day a week is approximately £9,000 per annum inclusive.

### Parenting and Family Support Strategy in Hillingdon

A multi-agency partnership group has been developing a 'whole system' approach to supporting parents commissioned by the Children and Young Peoples Strategic Partnership Board. It aims to:

- Oversee evaluation and monitoring of existing and future parenting initiatives
- Secure financial support via pooled budgets
- Ensure parental participation
- Define financial viability for a whole system approach and deploy a staged approach sustained within a determined financial envelope/pooled budget.
- Develop a parenting team to implement the strategy across the borough.

Hillingdon uses Triple P (Positive Parenting Program) as a model of parenting intervention based on its extensive evidence base and accessibility to different organisations and disciplines. Triple P is a multi-level system of parenting and family support specifically developed as a population level strategy. It has appealed to staff within Health, Education, Social Care and the Voluntary Sector. Over 160 practitioners, including community workers, education welfare officers, social care workers, clinical psychologists, health visitors and YOS workers have been trained.

#### Services Currently Provided

Universal, targeted and specialist services are provided for children, young people and their families. The strategy addresses national priorities as well as relating to Hillingdon's local context. Support services for parents and early intervention services fall into five categories:

- For parents of children with specific needs or conditions
- Services specific to the age of the child
- Specific to particular geographical areas of the borough
- Specific to particular groups or cultures
- Parenting training providers

Triple P Positive Parenting Programme applies principles and strategies derived from social learning theory to increase parents' self efficacy. It targets five core parenting principles: 1) creating a safe engaging environment for children, 2) creating a positive learning environment, 3) assertive discipline, 4) reasonable expectations and 5) looking after oneself as a parent.

Interventions have included media use, primary health care services, preschool, child care and school systems, worksites, and religious organisations.

#### How does Triple P work at a community level?

Level 1, a universal parent information strategy, provides all interested parents with access to information about parenting through a coordinated media and promotional campaign using print and electronic media, as well as user-friendly parenting tip sheets and videotapes which demonstrate specific parenting strategies. This aims to increase community awareness of parenting resources, receptivity of parents to participating in programmes, and to create a sense of optimism by depicting solutions to common behavioural and developmental concerns.

Level 2 is a brief, one to two session individual primary care intervention or a one to three session large group seminar program providing early anticipatory developmental guidance to parents of children with mild to moderate behaviour difficulties.

Level 3, a four session intervention, targets children with moderate behavioural difficulties, including active skills training for parents.

Level 4 is an intensive eight to ten session individual or group parent training programme for children with more severe behavioural difficulties

Level 5 (which is deployed in conjunction with Level 4) is an enhanced family intervention program for families where parenting difficulties are complicated by other sources of family distress (e.g. marital conflict, parental depression, or high levels of stress).

The rationale for this tiered multi-level strategy is that there are differing levels of behavioural and emotional disturbance in children, and parents have different needs and preferences regarding the type, intensity and mode of assistance they require. The multi-level strategy is designed to maximise efficiency, contain costs, avoid over-servicing, and to ensure the programme has wide reach in the community. The multi-disciplinary nature of the programme makes better use of the workforce in promoting competent parenting by providing flexible, evidence-based consultation tools.

### Outcomes

Work with complex families has improved. Virtual multi-disciplined/agency 'teams around the child/family' have been created and significant results have resulted as practitioners use the same approach. Parents are delighted, claiming that 'everyone is saying the same thing...I'm no longer getting mixed messages'. Families are remaining intact, children/young people who were in line for being placed out of borough are staying at home, demand for behavioural diagnoses has reduced and parents have declared that they are having better relationships with their children. Interventions have also appealed to parents who had 'given up on the system'. Parents on Parenting Orders find the model respectful and useful, often asking to continue the programme after their 'order' is no longer relevant.

## **Norfolk Family Support Teams**

The Family Support Teams (FSTs) are a county wide, community service, providing early intervention to children and young people (4-16 years) with emerging mental health problems. The service provides consultation and training to primary care professionals, parenting programmes and group-work for children as well as responding to individual referrals. Referrals are from professionals, rather than self-referrals. Service evaluation demonstrates positive outcomes for children and young people and a high level of service satisfaction from children and their parents/carers.

FST Primary Mental Health Workers (PMHWs) have developed partnerships with the statutory, voluntary and community sectors to deliver integrated services and to consolidate pathways, in particular from Primary Care between the FSTs and other specialist CAMHS. This reduces the delay for families when referrals are redirected between these services and frees GPs from the task of re-referring. Co-working and the delivery of accredited training are key elements in developing partnerships.

Enhanced confidence and skill level of the FST Primary Mental Health Workers has enabled them to work with increasingly complex cases, with consultation with more specialist teams rather than referring on. The service is starting work with children in care

FST has trained staff to deliver evidence-based programmes including the Strengthening Families Programme and has provided a 'One Stop Parenting Shop' in schools. It has delivered the Webster Stratton Parenting Programme and the One Stop Parenting Shops in the evening, reaching more fathers.

The service trains primary care professionals, developing their capacity to recognise and respond appropriately to the mental health needs of children through induction in CAMHS, student placements, co-working and workshops and courses.

Increases in referrals have been absorbed within current resources, using more focused ways of working, and increased provision of consultations. Waiting times for interventions have been significantly reduced. For example, the Northern Norfolk Team is now able to see all new cases within four weeks.

### **Newham Primary Care Professionals Foundation Training**

Newham CFCS, a specialist CAMHS in East London, has been running a CAMHS Tier 1 Foundation training course for five years. The training is offered to 35 participants from all sectors. The course consists of five morning sessions spaced fortnightly, a mix of didactic inputs and exercises, rounded off by lunch. The aims of the course are to create networks, raise awareness about CAMH issues and services, build bridges across sectors, define referral thresholds and to build on current local best practice, underpinned by service user feedback and best available evidence.

The course runs three times a year during academic terms. The trainers' philosophy is to offer the highest quality teaching to the maximum number of people in the shortest possible time; the course rolls out continuously in order to impact a highly diverse, high volume community of primary care practitioners and to allow for their time constraints.

The course integrates five CAMHS paradigms: biological, cognitive, affective, behavioural and systemic, so that more intensive courses can be built on to a coherent foundation. Session 1 provides a national and local CAMHS overview, rates, incidence, and diagnostics; Session 2 outlines a basic CAMHS assessment, linked to Every Child Matters (ECM) and the Common Assessment Framework (CAF); Session 3 focuses on working with complexity - families, groups, and networks; Session 4 highlights some basic issues on working with individual children and adolescents; Session 5 summarises learning so far and draws attention to issues of burn-out, teamwork and professional and personal development.

The course delineates five core skills at the heart of multi-agency work and these are threaded through the didactic and experiential teaching: the ability to ask questions whilst maintaining rapport; how to do a basic assessment; how to convene a meeting effectively; and how to work with motivation.

# Specialist CAMHS at Tier 4

## **Hertfordshire Outreach Team (pop of 1.2 million)**

This is a multidisciplinary outreach service for 12-18 year olds developed since 2001 from the Tier 4 service. It is part of a network of the adolescent inpatient unit, drug and alcohol service, YOT clinical workers and BEST workers.

The team now consists of 10.3 FTEs including 4 Community Psychiatric Nurses (CPNs), 2 psychiatrists, a social worker, Occupational Therapists (OPs), 2 sessions of a psychologist, administrator and an art therapist.

The majority of the patients are between 15-17 years, with significant numbers with psychosis, autism, emerging personality disorder, and conduct disorder, mainly referred from Tier 3 but also from AMH and Tier 4.

Audit showed that 45 per cent of the cases were offered a community package of care; 25 per cent were admitted; 30 per cent were for a second opinion. The outreach service works with young people before and after admission and co-works with community CAMHS. Until the EIP was cut recently, the team worked closely with their CPNs. Relationships are beginning with the newly established adolescent team in local children's social services.

Admission and emergency arrangements for 16 and 17 year olds: there are two ring fenced adolescents beds for 16/17 year olds on an acute adult ward. The aim is to develop specific adolescent skill on one adult ward as well as to smooth transition arrangements. It also allows police checking of staff on that ward and that Section 1 offenders are admitted to another ward.

CAMHS provide training to adult ward staff to work with adolescent patients.

A CAMHS nurse visits daily, working closely with the Responsible Medical Officer (RMO), a Child and Adolescent Consultant Psychiatrist for those beds.

The outreach service is part of the discharge/aftercare package from the ward.

AMH Crisis Assessment and Treatment teams provide weekend or more intensive cover for home treatments for acutely psychotic patients plus an accessible telephone night service.

Audit shows reduced admissions to other adult beds from 15 per year to 1 in 2005.

Service for 12-16 year olds: eight inpatient and two day patient beds for non-acute admissions. One contracted bed in an NHS unit and access on a preferred provider status to an independent provider for acute.

Comment

Outreach teams require significant staffing and cannot function without in-patient facilities. Despite high aspirations, even this Hertfordshire service has been unable to commission the acute young people's beds clearly and demonstrably needed. However there are plans to develop an acute unit in Hertfordshire and out reach will have an active role in initial assessments.

# Paediatric Liaison

## The Whittington Hospital

A multidisciplinary team totaling 1.6 WTE mental health professionals comprising psychiatry, psychology, psychotherapy, family therapy - supported by two full time LA social workers - all located in the hospital offers:

- Joint working in diabetes, sickle cell, oncology and neonatal intensive care;
- Participation in the weekly multidisciplinary meeting addressing problematic and complex cases;
- Clinical work with all hospital referred cases, both emergency and routine. The social workers dedicated to child protection work assess and provide early management of deliberate self poisoning and other acute presentations; and
- Staff development and training meetings with doctors, nurses and others.

# Children and young people with complex, severe and persistent behavioural and mental health needs

## **Multi-agency service for young people with complex needs - The Behaviour Resource Service (BRS), Southampton**

The BRS is a specialist multi-agency service for young people with complex needs, challenging behaviour and mental health problems. It was set up in 2000 as a DH funded CAMHS innovation project. Initially the central funding was matched by local funding from CAMHS and social services. In Southampton, a unitary local authority meant that BRS was funded from both social services and education.

The service works with approximately 50-80 young people each year, targeting those with the greatest needs. There are no exclusion criteria; service users may have difficulties including severe mental illness, drug and alcohol problems, learning difficulties, autistic spectrum disorders, homelessness, extreme risk-taking behaviours, sexualised behaviour, and brain injury.

The BRS has a four bed residential adolescent unit (staffed by a mixture of residential social work staff and Registered Mental Nurse (RMN)/Learning Disability (LD) nurses) as well as an assertive outreach community team (for ages 5-18).

Almost a year of intensive planning and dedicated project management was needed to plan and develop the service. The first year of team operation was characterised by issues about multi-agency team working and the core business of the service, different values and language used by different professions in different agencies. It has been important to develop an agreed model of comprehensive needs assessment and child-centred evidence-based interventions. The operation model has been adapted from Multi-Systemic Therapy (Henggeler et al.) to be more embedded in local children's services.

Some of the key issues which need to be addressed in setting up such a service include:

- Clear lines of line management, supervision and accountability are needed;
- A multi-agency management board has ensured a sense of joint ownership and shared strategic development, the provision of services valued by each agency, and each agency taking responsibility to contribute towards exceptional packages of care;
- Clear links and excellent communication is needed with a wide range of stakeholders in mainstream and voluntary agencies;
- Regular stakeholder consultation and user-feedback is needed to inform the operation and development of the service;
- All disciplines need to maintain a balance between generic tasks and specialist roles;
- Most professionals adapt to a culture of multi-agency working. But there is a minority who find it difficult to change their traditional roles;
- Professionals need to maintain links with their own professional groups for peer supervision, Continuing Professional Development (CPD) etc;
- It is difficult to design a meaningful evaluation of such a complex service. Each agency has its own particular interests such as educational inclusion and attainment rates, youth offending rates, Quality Protects outcomes for social services, particularly services for children looked after. Standardised outcome measures of mental health can be of limited value and there are important questions about their sensitivity to change with this group of service users. Data collection, poor return rates and analysis have all been challenging. Evaluation now focuses on user and stakeholder views, financial value (out of area placements);
- The value of reaching an agreed care plan for each young person cannot be underestimated;
- The BRS project has become established as a core service within Southampton and has resulted in significant changes to inter-agency understanding, co-operation and the development of collaborative working practices;
- The central funding was gradually reduced and stopped completely in 2006. The current operational costs amount to approximately £1.5M/year.

### Multisystemic Therapy

The Brandon Centre is a voluntary organisation based in Kentish Town, London that provides psychotherapy services for young people aged 12 to 21 years. The Centre also specialises in interventions for parents whose teenage child presents behaviour problems including delinquency and antisocial behaviour. With Cambridgeshire Youth Offending Service, it is one of only two services offering Multisystemic Therapy (MST) in England and Wales. The main goals of MST are:

- To reduce re-offending among high-risk young offenders;
- To decrease costs by reducing the use of custody and residential treatment and placement.

MST is a short-term intervention lasting 3 to 5 months that mainly involves the young offender and her/his parent(s). It is a community and home-based treatment that uses the strengths of the young offender and her/his parent to improve relations between them, peer relations, and school performance. Follow-up studies in the United States<sup>3</sup> — over \$10 million of research — have documented re-arrest rates 25% to 70% lower among MST cases compared to controls. Significant cost savings in policing, court and custodial budgets follow this. American research<sup>4</sup> has shown that MST can reduce days in out-of-home placements by 47% to 64%. MST is also useful in the treatment of young people engaged in substance abuse.

An MST team consists of an administrator, a supervisor and three therapists trained to deliver family, behavioural, problem solving and solution focused interventions according to MST principles. Each therapist can carry a maximum caseload of up to five families at any one time. The team's clinical work takes place totally in the community and therapists are available to their families 24 hours per day and 7 days a week. An MST team treats 40 to 50 families in a year at a cost of about £250,000.

The Brandon Centre has been running MST as part of a randomised controlled trial in partnership with Haringey Youth Offending Service and Camden Youth Offending Team evaluating MST against services as usual. The Centre hopes to report findings from this trial by 2008. The trial has already led some local authorities to commission MST from the Centre on a case-by-case basis.

# Services for Children in Care

## **Young People's Team – Leicestershire CAMHS**

The key objective is to provide specialist mental health service provision to vulnerable children, young people and their carers (in care, adopted, young offenders and homeless), who live within the health boundaries of Leicester, Leicestershire and Rutland. It is funded by the LA CAMHS grant and works collaboratively with Social Care. The dedicated specialist CAMHS team, co-located with generic specialist CAMHS, consists of mental health disciplines (primary mental health, nursing, psychology, psychiatry and family therapy). Specialist CAMHS interventions offered to these young people include: CBT, brief psychodynamic psychotherapy and more recently "theraplay", which is individual therapy based on the attachment framework, i.e. with the parallel involvement of carers, group parenting interventions based on an attachment framework and family/systemic therapy.

The team is directly accessed by agencies involved in the care of the target client groups, and is part of children's and young people's integrated social and health care pathways. The service objectives are delivered at different levels, through consultation, liaison and joint work, assessment, a range of treatment modalities, and training.

### **Multidimensional Treatment Foster Care In England (MTFCE)**

MTFC was developed and evaluated in the Oregon Social Learning Centre USA as a cost-effective alternative to residential treatment for adolescents with complex needs, severe emotional disturbance and challenging, including offending behaviour. The parenting training, for foster carers and the biological (or adoptive) parents, emphasises behaviour management to create a structured and therapeutic environment. The intervention combines high levels of supervision with positive parenting practices, seeks to decrease involvement with an anti-social peer group, and enhance involvement with school and positive recreational activities. A multi-disciplinary team, including CAMHS, social work and education delivers the programme, which is based on social learning and systemic theory.

The MTFCE programme has funded 19 teams; 12 have children currently in placements. 12 young people have graduated with positive outcomes. All those coming into the programme have a history of multiple placement breakdowns and complex needs. In MTFCE 70 per cent of children stay in placements for more than three months. Results so far show reductions in offending, violence towards others, self-harm, sexual behaviour problems and absconding. Placement in mainstream or special school is increased and frequent non-school attendance is decreased. Behaviour difficulties in school are reduced.

Challenges in implementing the programme include delivering an evidence-based programme in a local authority context and securing sustainable funding for the programmes, particularly from primary care trusts.

The MTFCE programme is in its third year and its current status is set out below:

- 39 children currently in the programme, 20 girls 19 boys
- 72 children admitted since beginning of programme
- 12 children "graduated" - 9 to long term foster placements, 1 home to family, 1 to independent living, 1 shared care
- 21 (29 per cent) children left earlier than planned
- Independent evaluation underway, including randomised control trial
- National Team collecting audit data

## Healthy Care

Healthy Care is a national programme developed by the National Children's Bureau (NCB), funded by the DfES, which aims to promote a healthy care environment for children in care and young people. It provides a multi-agency framework for local partnerships to achieve the five outcomes for children set out in Every Child Matters. It offers a set of tools and resources for local organisations to: audit local services; develop action plans; involve children, young people and their carers; evidence progress and provide information for inspection; develop training programmes for carers; and strengthen national and regional support networks.

# Youth Justice

## **Thames Valley Regional Child and Adolescent Forensic Mental Health Service**

A specialist child and adolescent forensic service, embedded in CAMHS, for young people within the Thames Valley area which covers Oxfordshire, Berkshire, Buckinghamshire and Milton Keynes, has been established.

The multidisciplinary team of four experienced clinicians, with a background in child mental health and work in the criminal justice system, engage with young people across a variety of custodial and other settings. The team is responsible for:

- mental health in-reach service to HMYOI Huntercombe;
- a specialist Tier 4 forensic mental health assessment service for young people;
- liaison with other institutions such as Secure Training Centres and YOIs within and beyond the region;
- development of a dedicated CAMHS/YOT mental health link worker network across the region;
- liaison with Youth Offending Teams (YOTs) and courts;
- liaison with national forensic adolescent services, locality CAMHS teams and adult forensic services;
- informing strategic development of mental health services for young people at the mental health/criminal justice interface within the region;
- training frontline practitioners in the criminal justice system (e.g. YOT workers, prison officers), CAMHS and other agencies;
- specialist training within the team for mental health practitioners wishing to specialise in the area of child and adolescent forensic mental health;

# Routine Outcome Monitoring (ROM)

## Sheffield CAMHS

Sheffield CAMHS is a member of the CAMHS Outcome Research Consortium (CORC). It has been using the Strengths and Difficulties Questionnaire (SDQ) and the Child Health Improvement Experience of Service Questionnaire (CHI-ESQ), across four community teams since 2004 and is now starting to use the Children's Global Assessment Scale (CGAS).

The SDQ is given to all families before they are seen. They either return it by post or bring it to the first appointment (there is a 50 per cent return rate which is slightly lower at first contact than some other services and may be due to administrative difficulties). Family members are invited to discuss their responses on the SDQ as part of the initial assessment with practitioners.

Sheffield has appointed a research assistant, who sends a follow up SDQ and a CHI-ESQ to all families 6 months after they are first seen. Currently, 37 per cent of follow up questionnaires are returned completed (this is higher than in some services.) In order to improve return rates, it is suggested that clinicians encourage completion of questionnaires over the phone or in the clinic/waiting room, when families attend an appointment around the 6 month point.

Results from these questionnaires are collated and the information shared with commissioners, service managers and the various teams for them to reflect on and respond to in the light of local circumstance and individual practice.

Practitioner support and ownership of the routine outcome evaluation is seen as vital to its success in improving services. Models of how to look at individual practitioners' outcomes in supervision and management are being explored.

The use of Psychology Assistant time and leadership and commitment from senior service managers has been invaluable to support the process. Successful implementation, including both measuring outcomes and ensuring that the service reports and responds to the findings, has required resources, in terms of administrative and clinical time.

# Delivering Race Equality

## **Building Bridges: working to develop and improve services for Black and Ethnic minority families. It provides:**

- A multi-lingual, multiethnic multidisciplinary staff group in Liverpool, working alongside adult and children's services across the voluntary and statutory sector.
- Offering services to adults, families, children and young people, including children with learning disabilities.
- One off consultations and regular work with clients; advocacy; family group conferences; bilingual support and advocacy for disabled children.
- Joint working with other services' clients and case consultation.
- Ensuring participation of children and families in service development, through stakeholder groups.
- Consultation to other agencies on service development.
- Training on working with issues of race, culture and ethnicity.

# Workforce Development

- New Ways of Working for Psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts”

This initiative was launched in 2005. The New Ways of Working in Mental Health CAMHS programme is supporting ten early implementer sites across England to implement this guidance. There is a grant available per site to progress innovative practice, service development and the associated service improvement in Child and Adolescent Mental Health for 2006/2007.

This programme of work will link closely to Creating Capable Teams (CCT). Its purpose is to help teams integrate the new ways of working into their team structures and practice in the multi-disciplinary environment of modern and comprehensive child and adolescent mental health services.

- A workforce planning toolkit for CAMHS is now being tested nationally across nine sites supported by NCSS.
- Work is currently taking place to develop a ‘CAMHS Education & Training Commissioning Framework’. This is intended to review existing training within CAMHS, provide a framework for future education and training and a local commissioning tool for CAMHS Partnerships.
- The regional project in North West England which supports the continued development of Primary Care Graduate Workers in CAMHS is being expanded nationally to explore further new roles within CAMHS linked to evidence-based practice, especially the NICE Guidelines on Depression, Anxiety, and Conduct Disorder.

# User Involvement

## **Hear Our Voice Young People's Mental Health Project, Truro**

Hear Our Voice is a voluntary, countywide organisation working with 11-25 year olds, experiencing or at risk of mental health difficulties. The need for the project was identified following concern about young people who were opting out or having difficulty engaging with statutory services, particularly relevant for those between 16-18 years who felt they did not fit into either AMH or CAMHS.

The team is multi-disciplinary/multi-skilled. The youth work approach is informal, aiming to empower the young people to make their wished-for changes. The aim is to develop self- awareness and insight into their mental health. The workers act as advocates for young people, helping them to have more control over their lives and decisions concerning their mental health and accessing the services and support they require.

Hear Our Voice uses art, music and more recently working with young people to produce literature in many different formats, including the production of CD-ROMs and DVDs. Feed-back information gained in this way is then fed back to appropriate organisations giving young people an opportunity to influence services.

The service has close working relationships with statutory and voluntary organisations including local CAMHS and Adult Mental Health Services. Young people are encouraged to get involved in the work of the project and develop a sense of ownership. We modify our service to meet the needs of our young people.

### The project provides:

- An easy self-referral route for young people, including texting and e-mails.
- Peer support groups running on a regular basis. These offer a creative supportive environment where young people can express their emotions and gain support from each other.
- Advocacy and One to One Support; the only young peoples' community based mental health advocacy service in the South West.
- Workshops raising Mental Health awareness in all the senior schools and colleges in Cornwall involving over 1400 pupils.
- Training; to organisations including Connexions, psychologists and other mental health workers. Young people are trained to participate alongside trainers, leading to NVQs or an equivalent award.
- Consultation; young people participate in the planning, evaluation and development of new and existing mental health provision.

How people who use services are involved: young people are pivotal in the development of the project; are consulted at every level; are represented on the Advisory committee and fully involved in the interview process for any new member of staff. They are consulted on new projects, help design and run programmes alongside the staff, and are central to our evaluation and monitoring process. They have designed and produced a series of pocket size leaflets on mental health and are involved in producing a pop DVD.

They have been involved in NIMHE South West events as part of the HOV team and one young person sits on National CAMHS committee with the manager and helped to organise and participate in their recent conference. All our peer groups can be involved to feed back material from CAMHS or to and from the Adult User Reference Group and directly into the Adult Mental Health Implementation Team. Young people are also involved in the monitoring and evaluation of the service.

# Choice

See also the section on Service Redesign on pages 10-11

## **CAMHS Choice 4 U**

CAMHS Choice 4 U is a programme launched by South Staffordshire Healthcare NHS Trust and their partners in February 2006.

The programme aims to carry out the groundwork to develop meaningful choice for children and young people who experience mental health problems. It is intended that all services, working with children and young people, will be included in the programme. The groundwork will identify:

- existing pathways into and through CAMHS.
- duplication within pathways with recommendations for improvements.
- choice points; which choices should be offered, where and when.
- information needed by clients, carers and staff to help them to navigate pathways more effectively.

A team including mental health clinicians, researchers, youth workers and information analysts is undertaking the development of:

- pathway maps
- local partnerships
- web-based information
- local feedback mechanisms to enable “real time” responsiveness
- workforce training
- support groups

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**Notes**

## Notes

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