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# When to see a child and adolescent psychiatrist

COLLEGE REPORT

# | Authorship

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# Introduction

Mental health services are going through a significant process of change, driven by many factors. These include the desire of patients to be more involved in their care, the new commissioning arrangements for health services in England, Northern Ireland and Wales, the financial pressures facing healthcare across the UK, changing professional roles and responsibilities for all clinicians, and the development of innovative services that are supporting patients, as far as possible, to receive treatment in their communities rather than in hospital beds. Child and adolescent psychiatrists will continue to champion those changes that will lead to better patient care and be uncompromising if changes will worsen patient care.

This report is written to clarify for commissioners, providers of mental health services, child and adolescent psychiatrists, our patients and our colleagues when patients should be seen by a psychiatrist to ensure that they receive safe, high-quality, evidence-based care. It is important at a time of such significant change that there is clarity about the roles and responsibilities of all professionals caring for patients within the multidisciplinary teams in which they work.

Many documents have informed this paper, including:

- *Seven Day Consultant-Present Care* (Academy of Medical Royal Colleges, 2012a)
- *Benefits of Consultant-Delivered Care* (Academy of Medical Royal Colleges, 2012b)
- *The Shape of the Medical Workforce* (Centre for Workforce Intelligence, 2012)
- *Safe Patients and High-Quality Services* (Mynors-Wallis, 2012)
- commissioning guidance for primary care mental health services and acute care (Joint Commissioning Panel for Mental Health, 2013)
- *The Abandoned Illness* (Schizophrenia Commission, 2012)
- *A Competency Based Curriculum for Specialist Training in Psychiatry: Specialists in Child and Adolescent Psychiatry* (Royal College of Psychiatrists, 2014)
- *Building and Sustaining Specialist CAMHS to Improve Outcomes for Children and Young People* (CR182; Royal College of Psychiatrists, 2013).

The document is set out in six sections.

- 1 What is a child and adolescent psychiatrist?
- 2 What do child and adolescent psychiatrists do?
- 3 When patients should be seen by a child and adolescent psychiatrist?
- 4 Child and adolescent psychiatrists in different settings.
- 5 What are the standards to which the child and adolescent psychiatrist will work?
- 6 Training and research and child and adolescent psychiatrists.

# What is a child and adolescent psychiatrist?

A child and adolescent psychiatrist is a medically trained specialist with skills in the assessment, management and treatment of mental health problems, disorders and illnesses in children and young people under the age of 18. The child and adolescent psychiatrist can also offer expertise in disorders starting in childhood and adolescence to adult mental health services during transition from child and adolescent mental health services (CAMHS) to adult mental health services. Like all psychiatrists, they are trained to integrate biological, psychological and social factors when working with patients (the bio-psychosocial model). Their training takes into account the following key features of working with children and young people:

- developmental changes are most marked during childhood and adolescence
- children have to be viewed in the context of their families on whom they are generally dependent, and definitions and compositions of the families are changing all the time
- the cultural context of the child is highly significant
- more often than in adult cases, the nominated child does not present themselves but is presented
- cultural mismatches between young people and their carers may affect presentations to mental health services and how they are managed (Dogra, 2014)
- children need to be understood in the context of their wider systems: school, local communities, healthcare, etc.

This document will focus on the role of the consultant child and adolescent psychiatrist. This reflects the fact that the consultant child and adolescent psychiatrist is a highly specialised clinician who has had many years of training and passed a series of theoretical and practical examinations. Child and adolescent psychiatrists in training can provide a useful service, which will always be under the supervision of an experienced consultant. Specialty doctors and associate specialists (in England, Wales and Scotland) also have an important role in service delivery and are supported through supervision and training to deliver high-quality care. The Royal College of Psychiatrists supports the Academy of Medical Royal Colleges (AoMRC) terminology to use the term consultant to include any doctor who is on the General Medical Council's (GMC's) specialist register.

# What do child and adolescent psychiatrists do?

In child and adolescent psychiatry, there is a longstanding focus on delivering care in community and out-patient settings, often integrated with other child and family services. CAMHS have been described as 'tiered' services (Department of Health, 1995). Tier 1 includes universal services (education, primary care, Social Services), tier 2 is targeted CAMHS, tier 3 is specialist CAMHS and tier 4 covers in-patient and highly specialist out-patient CAMHS. In Northern Ireland there is a five-step model that is equivalent to the tiered model. Consultant child and adolescent psychiatrists are predominantly based in tier 3 community CAMHS but often link to and sometimes work in tier 2 services. In-patient child and adolescent psychiatrists are increasingly working in conjunction with a broad range of services that aim to either avoid or shorten in-patient stays (tier 3+, outreach, crisis intervention, supported discharge – broadly described as tier 3+ (England) or community tier 4 (Scotland) in this document). This document considers a framework for the three most common service types which can act as a template for other areas. These are: community and out-patient child and adolescent mental health services (tier 2/3 CAMHS), in-patient child and adolescent units and tier 3+ or community tier 4 services. It is important to note that child and adolescent psychiatry includes all of the psychiatric subspecialties (intellectual disability, forensic, liaison, psychotherapy, etc.). This is reflected in this document.

The clinical role of a consultant child and adolescent psychiatrist sits alongside other important duties, including training the next generation of doctors. Consultants are at the forefront of research and innovation and play a significant part in the running of a successful organisation (Mynors-Wallis, 2012), alongside other colleagues within the multidisciplinary team.

## Assessment

Child and adolescent psychiatrists are trained to make a thorough assessment of the child/young person, which enables them to bring together all factors in the current presentation and history to both develop a formulation and make a diagnosis. A **formulation** is the considered summary of diagnosis, problem list and causation (recognising uncertainty where it exists). For children and adolescents this

includes key developmental factors, family and peer group factors, education and relevant social factors, including child safeguarding. The formulation is key to drawing up a management plan.

Consultant child and adolescent psychiatrists should be involved in the formulation of new cases and the assessment of complex cases because there is evidence that early consultant assessment and intervention improves patient outcomes (see Appendix 1). However, consultant child and adolescent psychiatrists are part of multidisciplinary teams, working with colleagues such as clinical psychologists, family systemic therapists, child and adolescent mental health nurses, child psychotherapists, social workers and other allied health professionals, often with high levels of professional skills. Consultant child and adolescent psychiatrists working in tier 2/3 settings will not have to see all children assessed by the teams that they work in. In many cases, consultation with colleagues and discussions in team meetings will suffice.

## Personal physician and therapist

The consultant child and adolescent psychiatrist has a role as the personal physician for a group of patients: not only those with complex and severe disorders but also those for whom a particular skill of the psychiatrist, for example medication management or understanding the links between physical and mental illness, is valuable. For many patients, a sense of continuity over time is important and within teams the consultant child and adolescent psychiatrist is important in ensuring that this sense of continuity is maintained. This does not mean the consultant child and adolescent psychiatrist sees every patient every time indefinitely: although this may be necessary for some patients, for others the consultant can lead the development of models of service delivery that achieve this sense of continuity by other means.

## Leadership and support for the multidisciplinary team

Consultants are responsible within their teams for providing leadership to ensure the delivery of high-quality care for patients. Although other members of the team may have important leadership roles, the consultant child and adolescent psychiatrist should provide **clinical leadership** for the team within which they work. A key aspect of leadership is the promotion of excellence in service delivery and in enabling others within the team to provide care of the highest standard.

Consultant child and adolescent psychiatrists have an important role within teams in the **management and containment** of risk and anxiety for patients with complex disorders and risky behaviours. This is achieved through the support of the team and management of clinical governance processes.

# Implementation of mental health legislation

Although other clinicians have important roles within mental health legislation, it remains the case that a significant part of this work is done by consultant child and adolescent psychiatrists, who need to have sufficient time to undertake the tasks to the high standard expected.

A consultant child and adolescent psychiatrist should be involved in the care of any patient who has a mental disorder, or possibility of a mental disorder, and one or more of the following factors are in place:

- 1 The nature of the mental disorder requires psychiatric care.
- 2 Risk to self or others.
- 3 Poor engagement with service or abnormal illness behaviour.
- 4 A need to respond authoritatively to another agency.
- 5 Complex psychopharmacology is required or being prescribed.

# When patients should be seen by a child and adolescent psychiatrist

## 1. The nature of the mental disorder requiring psychiatric care

Mental illness is common in the general population. The widely quoted figure of 1 in 10 indicates that 10% of the childhood population will have a mental illness at some stage during their childhood (Green et al, 2004). It is clearly not feasible, nor desirable, that all of these patients should see a consultant child and adolescent psychiatrist. However, there are specific conditions and circumstances when the involvement of a consultant child and adolescent psychiatrist is recommended. Generally, child and adolescent psychiatrists should be directly involved in the assessment and management of children, and children and young people presenting with more complex, more severe and more high-risk problems. Consultant child and adolescent psychiatrists are experienced therapists who can combine a variety of approaches and so should be able to provide therapy to children and young people with complex and high-risk problems (e.g. combining psychotherapy with pharmacotherapy or individual with family approaches).

Child and adolescent psychiatrists are skilled in working with children and families with complex disorders, where an understanding of the interplay between biological, social and psychological factors is important and where multimodal interventions are indicated. Child and adolescent psychiatrists involved with the care of children and young people with these types of conditions may be involved in direct assessment and treatment but may also provide consultation and liaison to services, without necessarily seeing the child and their family.

Children and young people with mental health problems are often subject to multiple risk factors: psychosocial adversity, physical health problems, developmental delay and disorder, complex family relationship, school difficulties, parental mental illness. Children with physical health problems and children whose parents are experiencing mental health difficulties warrant a lower threshold for the involvement of a child and adolescent psychiatrist.

The following is a list of mental health conditions in the management of which child and adolescent psychiatrists play a significant role. The list is representative, not exhaustive:

- children with developmental disorders such as autism spectrum disorder, intellectual disability and attention-deficit hyperactivity disorder (ADHD)
- children with emotional and behavioural problems, particularly when parental mental illness is a significant factor in the child's presentation
- depression and anxiety disorders (generalised anxiety, obsessive–compulsive disorder etc.)
- first presentations of psychotic disorders
- substance misuse amongst children and young people with comorbid mental health problems
- children and young people with eating disorders need comprehensive assessment of both physical and mental health needs; they often need multi-modal intervention, sometimes including psychopharmacology, and often experience complex comorbidities (anxiety, depression, autism spectrum disorders); consultant child and adolescent psychiatrists should be directly involved in the assessment and treatment of these young people
- children and young people who have experienced complex trauma (often in the context of child abuse)
- young people with emerging emotionally unstable personality disorder.

## 2. Risk to self or others (including emergency departments and paediatric liaison)

Child and adolescent psychiatrists have a key role in the multidisciplinary assessment of risk to both self and others. Patients and carers rightly expect that a consultant child and adolescent psychiatrist will be involved in the assessment and management of all patients for whom significant risk is identified. These include **patients who are at risk of harming themselves, at risk of harming others or vulnerable to neglect**. Child and adolescent psychiatrists have particular expertise in the safeguarding of children. Because of their knowledge of mental health, they often have a specific role to play in the safeguarding of children with parents with mental health problems. Service models that triage initial assessments to other professionals should ensure that all new cases are discussed with a consultant child and adolescent psychiatrist.

A consultant child and adolescent psychiatrist should also be involved in all cases **where there is potential risk to others**. A child and

adolescent psychiatrist should be involved in the assessment of and formulation for all children and young people who have made a significant attempt to harm themselves, when this is done in the context of a mental illness. Initially this can be by consultation and discussion with the assessing clinician, but where there is a high level of risk or complexity, direct involvement is indicated. This is to ensure that the management plan reflects a clear plan for treatment of the mental illness as part of the amelioration of risk. Individuals with mental illness present symptoms through a prism of social and personality factors and physical illnesses. An accurate assessment and diagnosis is not always straightforward. Patients and their carers rightly expect a thorough diagnostic formulation, particularly when risk is involved, acknowledging uncertainty where it exists, in order that they can be fully informed as to the evidence-based treatment options. A consultant child and adolescent psychiatrist should be involved in and lead this process.

### **3. Particular issues around engagement with service, abnormal illness behaviour**

Some patients have difficulty in accessing services or show challenging or abnormal illness behaviour. Patients with these problems need a consistent, bounded approach and input over a protracted period of time. A consultant child and adolescent psychiatrist is often best equipped to support these patients and the team members trying to help them.

### **4. A need to authoritatively respond to another agency**

Mental health services are sometimes asked by other agencies to provide an assessment of risk or advice on the management of challenging behaviour. In certain circumstances, a consultant child and adolescent psychiatrist will be best placed to do this, and can also help mental health services maintain appropriate boundaries around/in relation to the remit of service delivery.

The treatment regime for many patients with significant mental health problems involves the use of medication. Medication regimes that are known to benefit patients can often be complex and there are important judgements to be made by the patient about risk and benefits that should be informed by the expert view of the consultant. Many patients have physical health problems and it is important that prescribers have an understanding of the interaction between physical and mental health and also the potential for untoward drug interactions.

# Child and adolescent psychiatrists in different settings

## Community CAMHS

Consultant child and adolescent psychiatrists in community CAMHS teams play a key role in the assessment, formulation and diagnosis of complex cases. They also play a key role as clinical leaders in community teams and, as medical practitioners, a central role in the management of children with comorbid medical conditions. Consultant child and adolescent psychiatrists will not see all the children and young people in community CAMHS, but will often provide consultation and supervision to other professionals within the service. In limited circumstances, consultant child and adolescent psychiatrists will be involved in delivering therapy for children and young people with complex and high-risk problems.

## Links with primary care

General practitioners (GPs) value links with consultant child and adolescent psychiatrists, whom they can call upon for advice and support about individual patients. As one GP respondent to the Academy of Medical Royal Colleges' consultation on the benefits of consultant-delivered care said, they would 'welcome greater opportunities to speak to or email a consultant who directly knew the patient and had the authority to see the patient sooner or change their management plan as necessary' (Academy of Medical Royal Colleges, 2012b). Easy two-way communication between the consultant child and adolescent psychiatrist and GP can help facilitate better care for patients in transfer between primary and secondary care, and benefit patients continuing in primary care, giving them swift access to secondary care when necessary.

For children and young people, primary care encompasses a range of agencies. For this reason, consultant child and adolescent psychiatrists play a significant role in liaising with a wide range of services: general practice, hospital and community paediatrics, education, social care and the voluntary sector.

The consultant child and adolescent psychiatrist in the community CAMHS team will be involved in the reviews of complex patients who are often cared for under the care programme approach (CPA) (care and treatment plan (CTP) in Wales). In Northern Ireland, the promoting quality care approach is used to manage children and young people who are at high risk. The child and adolescent psychiatrist should be involved in ensuring safe, high-quality care plans are in place and be available to support other professionals in the care of such patients. There should be care plans for all patients, not just those on CPA (CTP in Wales). Making sure this happens is the responsibility of the whole team and should be followed up through governance processes. Team meetings are a way to access consultant input and involvement in care plans.

All patients, regardless of age, want to see an expert with the knowledge and skills to address their problems and provide them with the highest standard of care. Expert consultant care should enable fuller and better information to be shared with young patients and their relatives. This includes reducing the scope for misinformation, lending support, shared decision-making and minimising complaints and confusion. There is evidence that consultant involvement in a patient's care can increase the patient's and their family's overall satisfaction with care (Academy of Medical Royal Colleges, 2012b: p. 28).

## Child and adolescent in-patients

In-patients can present the greatest challenges to the service. It is expected therefore that each consultant should have sufficient time to personally review each patient at least once a week. There is evidence that length of stay is reduced if patients are reviewed by a consultant, with discharge planning starting earlier in the admission process.

Psychiatric in-patient care entails careful assessment of the child and their family and detailed understanding of the child's system (school, social circumstances, etc.). This understanding arises from the personal relationship that the consultant forms with their patients in the in-patient setting. Admissions to in-patient units can occur either as emergencies or as planned events. However, discharges and changes to treatment often entail careful consultation with the child and their wider system. Key decisions about a young person's care are best made by the consultant child and adolescent psychiatrist, who knows the young person and their family best. However, if there is an acute change in a child or young person's presentation out of working hours, urgent review by the duty consultant child and adolescent psychiatrist would be indicated.

All consultant child and adolescent psychiatrists have some responsibility for the physical health of their patients in an in-patient setting. However, the in-patient consultant child and adolescent psychiatrist has the primary responsibility while the patient is in their care.

Approximately 10% of children and young people have a chronic health condition (Reulbach *et al*, 2010). The early features of the metabolic syndrome, particularly weight gain, often appear in young people with early-onset psychotic disorders. Equally, re-feeding syndromes can emerge in children and young people with eating disorders. The in-patient admission process provides a good opportunity to conduct a thorough review of a patient's physical health problems so that, on discharge, a clear management plan can focus on both physical and mental health issues.

## The tier 3+ or community tier 4 team<sup>a</sup>

All patients in a tier 3+ or community tier 4 team should be reviewed by a consultant child and adolescent psychiatrist, reflecting the fact that these patients are very unwell and that, were it not for the tier 3+ team, they would be an in-patient. These reviews should take place at least once a week.

Entry and exit from a CAMHS tier 3+ or community tier 4 team should entail review by:

- in-patient consultant child and adolescent psychiatrist preceding discharge, or
- community CAMHS consultant preceding outreach team referral.

Children and young people who are under the care of a CAMHS tier 3 + or community tier 4 team should receive regular consultant child and adolescent psychiatrist reviews. This is particularly so if there is a change in presentation or a change in plan from that expected by the consultant referring into the service. There should be a consultant review to ensure that the decisions made will provide high-quality, safe patient care and are fully understood by patients and their carers. Parents, carers and young people should have a copy of their care plan communicated in a form appropriate to their competency/capacity.

A key role of the consultant child and adolescent psychiatrist in the CAMHS tier 3+ or community tier 4 service is to ensure that there is a seamless transition in care between teams and that patients and their families are fully involved with decisions that are made.

Following a significant episode of self-harm, it is expected that patients who have been assessed by other members of the multidisciplinary team should be discussed with a consultant child and adolescent psychiatrist, if they are not already in the care of a mental health service. A significant episode of self-harm is one that leads to a presentation to an accident and emergency (A&E) department for treatment or assessment.

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a. In Northern Ireland, specialist community-based, multidisciplinary CAMHS would be described as 'providing care at step 3'. Tier 3+ would be equivalent to step 4.

# What are the standards to which child and adolescent psychiatrists will work?

Child and adolescent psychiatrists wish to provide high-quality, safe, personalised care for patients and rightly expect to be judged according to this standard. To deliver this standard of care, consultant child and adolescent psychiatrists need sufficient time, in both out-patient and in-patient settings, to engage with patients and their families/carers as partners in care. They also need sufficient time to support other members of the multidisciplinary team in providing such care.

Child and adolescent psychiatrists are expected to know and utilise national guidance with regard to the treatment of psychiatric disorders. However, it is often the case that treatments are not set out in guidelines for patients with complex disorders and those who have failed to respond to first- and second-line interventions. The consultant child and adolescent psychiatrist's expertise and judgement then comes into play in determining treatment plans and also monitoring their effectiveness and, in limited circumstances, delivering therapy for children and young people with complex and high-risk problems.

It is not expected that a consultant child and adolescent psychiatrist will document every aspect of an assessment or care pathway. This would be excessively time-consuming and bureaucratic. However, consultant child and adolescent psychiatrists should document reasons why clinical decisions are made, particularly when there are changes in decisions, and when decisions are made that are outside a recommended pathway of care, in relation to patients whose care they are directly involved in.

# | Training

It is important, if we are to train the next generation of child and adolescent psychiatrists, that there are opportunities for them to be trained in a broad range of mental health diagnoses and interventions.

It is not possible to become an expert without having had experience of patients with less complex diagnoses. There is an important role, therefore, for consultant child and adolescent psychiatrists to supervise their junior colleagues in the assessment and management of patients who could be managed by members of the multidisciplinary team or by their primary care colleagues; it is important the child and adolescent psychiatrist in training gains sufficient experience to manage more complex cases and emergency child psychiatric presentations in the future. Service reorganisations must take into account the implications for training to ensure that services continue to have a supply of appropriately and broadly trained individuals to become the experts and leaders of the future.

It is also important that there is an opportunity for the child and adolescent psychiatrist in training to have experience of making decisions in all settings, including out-patient clinics, crisis and home treatment teams, in-patient settings (including secure hospital settings and prisons, where relevant). Training experiences must be available over the 24-hour period and 7 days a week.

Child and adolescent psychiatrists need to be trained not only in diagnosis and formulation, but also in how to establish and maintain and therapeutic alliance with patients. Psychiatrists also need to have training in leadership to enable them to provide effective clinical leadership to multidisciplinary teams.

The most recent National Health Service (NHS) reforms establish research as a core activity, for which consultant child and adolescent psychiatrists must take significant responsibility. All consultants should support research, and use their perspective and training to affirm its value, both as the foundation of evidence-based care, but also as an activity that improves care itself. Patients in clinical trials have better outcomes than patients treated 'as usual'.

# Appendix 1

The Academy of Medical Royal Colleges' (2012b) document on the benefits of consultant-delivered care notes:

'Early consultant assessment and intervention ensures that the patient starts earlier on the right pathway of care with opportunity for improved outcomes. In emergency and acute medical care settings this has the potential for immediate dramatic differences in outcome. There is limited statistical data from English hospitals that suggests that the presence of emergency medicine consultants in the Emergency Department may reduce hospital admissions from between 12 and 25% [...].

Advanced clinical skills achieving better outcomes and being better placed to manage uncertainty and to respond when there are unexpected complications of unusual circumstances. Hospitals have demonstrated improved outcomes on medical acute admissions units, with reductions in unnecessary admissions, length of stay and readmissions after the introduction of additional consultant ward rounds in the evenings and weekends. [...]

Consultant presence. The recent report from NHS London provides strong evidence on the differing mortality rates depending on weekday/ weekend consultant presence. The Royal College of Paediatrics and Child Health (RCPCH) reported a study of infant deaths which found that babies born outside the hours of 9am to 5pm, Monday to Friday, were more at risk of dying and that a lack of immediate access to senior staff at weekends contributed to this outcome.' (p. 14)

There is every reason to believe the benefits found for consultant care in acute settings apply to mental health settings. However it is important to note that in in-patient child and adolescent settings, detailed knowledge of and engagement with the child and his/her family may not always be available to consultant child and adolescent psychiatrists providing out of hours cover. It is this detailed knowledge and engagement that underpins effective and safe discharge planning.

The Academy explains why consultants have a key role in making rapid and appropriate decision making as follows:

'By definition consultants are the section of the medical workforce with the most experience and training. As a group, they are the highest skilled group of doctors. Whilst this may be self-evident it is important to articulate what this means in practice.

A consultant has the breadth, depth and length of experience not just to recognise diagnoses, take action, investigate appropriately and initiate treatments, but also to acknowledge the unusual, unexpected and unfamiliar. They make rapid and appropriate decisions that benefit patient care. Fully trained doctors use their greater experience and knowledge in primary, elective and emergency care.' (Academy of Medical Royal Colleges, 2012b: p. 13)

Consultants should be involved in the assessment of all patients admitted to hospital within 24 hours of the admission reflecting the fact that seven day consultant presence improves patient outcomes. The Academy of Medical Royal Colleges has developed three patient-centred standards to deliver consistent in-patient care, irrespective of the day of the week.

## Standard 1

Hospital in-patients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway. What this means in practice is that the status of every in-patient whose care pathway would be altered by daily consultant-led review should be considered at least once in every 24 hour period.

## Standard 2

Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay. What this means in practice is that the progress of a patient along their care pathway should not be delayed because investigations or interventions are not available on certain days of the week. While the delivery of the intervention or investigation may be delegated to any appropriately trained and competent clinician, the overall provision of the service should be supervised by a consultant.

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