

SAMPLE CHAPTER FROM:

Child and Adolescent Mental Health Services

An Operational Handbook (Second edition)

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Introduction

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‘The world is disgracefully managed, one hardly knows whom to complain to.’

Ronald Firbank, *Vainglory*

Purpose and scope of the book

Child and adolescent mental health services (CAMHS) comprise a small, unusual specialty often ill understood by those who work within, those trying to use and those trying to commission them. In an attempt to make order out of the possible chaos, *Together We Stand* (NHS Health Advisory Service, 1995a) offered a review of and a strategic framework for, the organisation and management of CAMHS. This strategic approach was sanctioned by the House of Commons Health Committee (1997) and provided the benchmarks against which CAMHS have been measured (Audit Commission, 1999). Unfortunately, since the publication of the first edition of this book, the application of the principles and strategic approaches that informed *Together We Stand* has been subject to individualistic variation.

The tiered system has been bastardised or ‘moved on’ over the past 10 years to an incomprehensible ‘lingo’ in which many writers assume all ‘specialist’ or ‘core’ CAMHS operate at Tier 3, and Tier 2 has been confined to limbo, beneath the dignity of so-called ‘senior professionals’ of whatever discipline. The differing interpretations have resulted in the very confusion about services that the tiers were intended to overcome, so the risk of the confusion that reigned prior to 1995 has reoccurred, indeed it has been amplified. There is a serious risk that CAMHS will again become marginalised as they cannot be understood and are subject to changes and targets from those in power who do not understand their functioning, as advisors to government ministers have no real understanding of what the tiers are about. The tiered system is an integrated approach in which CAMHS professionals work across tiers: it is not and cannot function as a hierarchical system in which ‘senior clinicians’ are seen to operate at Tiers 3 and 4 only. The creation of ‘Tier 2 teams’ is a contradiction in terms, and reinforces the hierarchical attitude that only senior staff work at Tier 3 and above, which undermines both an integrated approach and true multidisciplinary working. It is worth restating the following.

- Tier 1 is the services provided by people who in the normal course of their professional lives have an effect on children's mental health (e.g. teachers, social workers). There have been tremendous developments in Tier 1 in recent years with the establishment of Sure Start (Department for Children, Schools and Families, 2009), Healthy Schools (www.healthyschools.gov.uk) and organisations such as Connexions (www.connexions-direct.com), and CAMHS have an onerous responsibility in supporting their work through consultation and advice.
- Tier 2 is an integral part of 'specialist CAMHS' or 'CAMHS proper' and is where individual CAMHS professionals practice their individual skills as part of the multidisciplinary CAMHS. Professionals operating at Tier 2 must be able to undertake a full and competent assessment, and that assessment needs to be holistic in assessing the many difficult predicaments the child and family may find themselves in. Just looking for a diagnosis that leads to a treatment package is too simplistic. Any CAMHS professional who doesn't have the skills to work on their own is a waste of CAMHS resources. Primary mental health workers provide a very effective bridge and gateway between Tier 1 and community CAMHS; one of the most effective and reassuring interventions for Tier 1 professionals is consultation (Wyatt & Richardson, 2006; details available on request from the author) and this should be an integral part of any CAMHS professional's work.
- Tier 3 includes teams within a 'specialist' or 'core' CAMHS, with a team structure and approach targeted at particular problems (e.g. an eating disorders team or an attentional problems team). Therefore, Tiers 2 and 3 constitute CAMHS secondary care.
- Tier 4 is very specialist services such as in-patient care, a mental health liaison service to a paediatric service or a service for deaf children with mental health problems.

The tiers are clearly laid out in the document that spawned them (NHS Health Advisory Service, 1995a) and the tendency to use the term Tier 3 for specialist, core or community CAMHS seems to arise from some CAMHS professionals requiring a status reflection of their own self-importance. This handbook sticks to the clear system advocated in *Together We Stand*, in which CAMHS is composed of staff working in Tiers 2–4, and Tier 3 are specialist teams within a CAMHS such as a bereavement team or a learning disability team. In this book, CAMHS refer to generic services for child and adolescent mental health problems provided by the National Health Service (NHS) or independent health providers. Teams refer to specific groups of CAMHS professionals working on specific tasks within a generic CAMHS (e.g. an eating disorders team or an attentional problems team), but which may also involve inter-agency working with staff who are not employed by health services (e.g. social workers in a looked-after children's team).

It is important to have an effective and properly resourced national CAMHS for mental disorders as mental health problems affect 10–20% of

children (Fombonne, 2002) and appear to be becoming more prevalent. With a finite supply, this ever-growing demand on CAMHS has rightly stimulated the development of community-based initiatives in which effective working with and into Tier 1 is an essential function of provision. All CAMHS professionals must work across all tiers, all must have a 'consultant' function, and all services must be able to identify not just what they do but what they do not do. Expansion of services into ever more specialist niches may do wonders for individual or disciplinary imperialism, but there is a danger of devaluing and undermining so-called 'bread and butter' provision with a consequent impact on the mental health of the wider community. A useful CAMHS will have negotiated with commissioners and partner agencies what its priorities must be.

Child and adolescent mental health services must be responsive to change whether in terms of identified need, legal structures, governmental policy, clinical practice or priorities, while maintaining stability and continuity in service delivery. It is a mature service that recognises that reorganisation and refocusing for its own sake as a mere reactive impulse to any new stimulus results in chaos, uncertainty and dissatisfaction.

This second edition describes how the strategic framework described in *Together We Stand* (NHS Advisory Service, 1995a) can be put into practice by further developing and updating the principles of clinical management to the delivery of CAMHS. This is not a text describing clinical work at any one tier, although the provision of any service must be thoroughly informed by a relevant understanding of clinical need and practice. It is a description of how the nuts and bolts of the organisation of CAMHS delivery can be put together at each tier and between tiers to provide a robust, patient-centred, clinically effective service. The handbook addresses the interface between all tiers and the development of effective operational structures that allow for professional functioning in an integrated fashion. The settings in which such practices operate have been extended in this edition. The book concludes with the reflections of a Chief Executive who identifies not only what he expects of a service, but also what a service can legitimately expect of him.

The handbook remains geared to those from all disciplines working in CAMHS as well as those responsible for their organisation. The editors consider that the handbook will be helpful to commissioners, as it details how services should be organised to ensure value for money when commissioning CAMHS at whatever level (Morley & Wilson, 2001). The text is underpinned by research evidence as well as government policy, but also by reference to experience, achievement and opinion.

This is not a textbook for Tier 1 professionals looking to develop services for children with mental health problems. However, the importance of the support of Tier 1 and the interface between Tier 1 and other CAMHS provision is emphasised in Chapter 13. The development of formal links as well as informal understanding of relative functions is part of the relationship building that is at the core of the effective operation of CAMHS.

The developing role of the voluntary sector and client interest/support/pressure groups has affected the nature of service provision. Fortunately, patient partnerships are inevitable in CAMHS as it is not possible for CAMHS to make any useful intervention without full patient and family participation in managing the difficulty presented. However, more formal links must be developed and effective networks established with such groups so that they can truly become partners in service delivery. The voluntary sector has developed differently in different parts of the country, with different agencies taking different priorities; it is therefore difficult to be prescriptive. However, commissioners should certainly involve voluntary agencies when planning and developing CAMHS for which they are responsible.

Principles considered

Multi-agency, multiprofessional liaison, cooperation and management

Children come into daily contact with any number of different professionals who influence their mental health. Any agency that purports to be interested in the mental health of children must work with all professionals, whatever agency, voluntary or statutory, or profession they come from. Child and adolescent mental health services must therefore work with all other agencies involved with children. Similarly, a competent CAMHS cannot hope to meet children's needs without the input of different disciplines, each offering differing perspectives and knowledge bases. The management of each agency and service must understand the need to work with other agencies and services to ensure integrated services. Professional and organisational boundaries, which encourage professional and organisational imperialism have no place in a service that puts children and their families at its centre.

Systemic approaches

Children thrive in some systems and do badly in others (Rutter *et al*, 1979). Viewing pathology as lying within the child so that they are assessed individually and out of context does not serve the child well, and can often lead to stigmatisation and foster low self-esteem, not to mention absolving adults involved with the child from any need to change their behaviour. This handbook takes a systemic approach and looks at organisational matters that promote mental health, as well as the organisation of individual interventions geared to the needs of the child in the predicament in which they find themselves. This does not mean that children with individual problems such as autism or anorexia nervosa do not require management packages tailored to their needs, but those packages must be provided in a

manner and within an organisational structure that systemically supports their mental health. This handbook remains based on the premise that a systemically healthy CAMHS will be more effective than a collection of non-interacting mental health professionals.

Clear structure, terms of reference and operational policy

In order to meet the generally increasing demand upon services and to meet ever proliferating targets and guidance, the organisational structure of any CAMHS must be explicit in terms of both the service that can be offered and the service that cannot. This will involve a degree of prioritisation and, at times, rationing, as we identify that which we are not able or qualified to do. This position is often muddled by the creation of waiting lists in acceptance of the out-of-date mechanics of responding to referrals rather than managing and restructuring the referral process as described in Chapters 11 and 12. Child and adolescent mental health services need to move away from the linear notion of referrals, which is clearly inadequate as only 10–25% of children with mental disorders and mental health problems are referred to such a service (Fombonne, 2002). A system is required that involves work with children and families based upon need through multi-agency and multiprofessional liaison, cooperation and management. Those who commission or need to use a service or team within CAMHS have the right to know how that service or team operates. It also helps the service or team to understand its own function and for the induction of new members for it to have developed a clear operational policy.

Integration between tiers

The advantage of the tiered structure and multidisciplinary working is to move away from medical model-based systems, defined by finished consultant episodes (a period of admitted care under a consultant within an NHS trust) and face-to-face contacts, with the consequent medicalisation of child and family development, to a system where intensity of input is geared to complexity of need. The tiered system is one of organisational structure that supports such a method of service delivery, each CAMHS professional having the potential to work at, or with, more than one tier.

Different services will have both different resource levels and different skill mixes, and this will affect their provision. A CAMHS will need to have sufficient professionals within it to provide a comprehensive Tier 2 service and to form a comprehensive range of Tier 3 teams. However, each of the identified clinical needs can be managed at different positions within the tiered system, depending upon local circumstances. The effective management of CAMHS is dependent on recognition of the interface between the tiers and a close working integration of them all. In clinical terms, a linear approach to the tiered system will result in its failure, whereas a systemic understanding will allow it to function effectively.

Integration of organisational structure

Although CAMHS are generally small, they are sufficiently different from other health service provisions that they require their own discrete managerial and organisational structure and commissioning processes. Only then will there be allowance for the greater sophistication and specificity in understanding of service delivery and consequent financial management, including effective costing, of the different aspects of service provision, which will be essential when 'Payment by Results' (Department of Health, 2009) is introduced. An example of the need for an understanding of CAMHS complexity and the integration of all tiers is in the commissioning and provision of Tier 4 in-patient services. The need for such services may decline with effective community provision at Tiers 1, 2 and 3, but they will still be required, albeit possibly with fewer beds. In the short term, such services may appear both over-expensive and over-staffed, thereby offering the scope for financial savings in times of cutbacks. However, if locality CAMHS withdraw resources from Tier 4 provision, such provision will disappear and not be there on the few occasions when it is required. Such disinvestment by the NHS is indeed happening, and so between 2001 and 2006 the independent sector had moved from providing a quarter to a third of in-patient provision (O'Herlihy *et al*, 2007). The integration of the tiers rather than fragmentation of CAMHS by separating the tiers will allow for a full provision of services for young people from their communities through to the most specialist provision.

Caring for the carers

A service that does not care for itself is likely to have difficulty caring for others – a fact often overlooked within the caring professions. Working in CAMHS is a tiring and often emotionally draining experience. There must be formal lines of responsibility, accountability and supervision in place, as well as access to training, so that people feel professionally secure and supported by the organisation and their colleagues; this is described in Chapter 7. A sense of perspective must be maintained so that we do not take ourselves too seriously. There is a place for insensitivity, black humour, prejudice, irritation, frustration and irrationality – all those defence mechanisms essential to our sanity. There is a myth of the objective, detached professional who can shed personality, beliefs and values on entering a professional arena – it is a myth that can lead to burn-out and professional underfunctioning. Child and adolescent mental health services work with reality rather than ideals. A simple structural entity can aid this process, namely the staff room or common room. This should be a place wherein the shackles of professional responsibility can be loosened in the comfy cushion of shared coffee or lunch, a place where folk can meet and discuss the problems bothering them, and gain advice and support in their ongoing practice, or just let off steam and be unreasonable and uncaring.

Evidence-based practice

The Children Act 1989 requires that any intervention into a child's or family's life should result in a demonstrably better situation for the child than not intervening. This is a principle, along with the Hippocratic injunction of 'first, do no harm', that can and should inform our clinical practice. In CAMHS we are faced with a wide range of what can broadly be termed 'mental health problems' causing considerable psychological distress and morbidity, although we face a small range of specific diagnosable mental illnesses (Meltzer *et al*, 2000), and public perspectives of referral to a CAMHS will tend to focus upon the latter. Any service provision for distressed members of society cannot be an exact science, ratified by double-blind randomised controlled trials (RCTs) as many problems often occur together and are difficult to disentangle, but all need addressing to alleviate the distress: the care, support and treatments offered are as much an art as a science.

Referral to a CAMHS may result in the labelling and stigmatisation of the child and family, as well as in the deskilling of the parent. A systemic understanding must always inform our knowledge of the evidence base. Our work should, of course, be focused, problem-solving, collaborative and, where possible, short term. Beyond this, we should always consider the effect of any CAMHS intervention, which starts in the mind of the child and family long before their first consultation with the referrer. When considering a CAMHS response, those processes preceding referral must be weighed in the balance of mental health pros and cons, so that the response is geared to positive mental health rather than increasing mental health problems.

Services described

Throughout this book, the above principles are paramount and guide the service delivery described. To avoid repetition, the following principles can be considered to guide the authors of all the chapters in both the management of the service and the development of effective clinical provision.

- The CAMHS is based on multidisciplinary working.
- It represents a responsive service that offers advice and support, and that avoids stigmatisation and the disempowering of families; that is, a service that is child- and family-centred and that dovetails with services from other agencies.
- The CAMHS takes on board the social, educational, emotional and medical needs of the young person and family.
- The service provides clear information to other services and agencies about routes of referral and consultation.
- There is a clear operational policy for each professional, team and service that details skills, accessibility and comprehensiveness.

This handbook was conceived as a manual for those wishing to put their CAMHS in order. Inevitably, it takes a CAMHS perspective. However, the need for CAMHS to work with other agencies and for them to understand CAMHS is overwhelming and the principles underlying the handbook dictate a multi-agency perspective.

The services described in this book are based within the legislative framework of England, much of which also pertains to Scotland, Northern Ireland and Wales. There will be differences in details, as a result of initiatives in the devolved UK (e.g. National Assembly for Wales, 2001). However, the principles of CAMHS delivery will remain the same if services are based on need and effectiveness rather than professional or legal nicety.

Any service exists, as indeed do patients, in a context and, as such, both influence and are influenced by relational factors, be they internal (within a CAMHS) or external (e.g. government or trust policy). Organisational change within the NHS has no discernible end-point, so this handbook is heavily informed by reference to ‘what works’ for both provider and recipient of CAMHS provision, but will clearly have to develop as government policies, societal mores and research dictates.

References

- Audit Commission (1999) *Children in Mind*. Audit Commission Publications.
- Department for Children, Schools and Families (2009) Sure Start children’s centres (<http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/whatsurestartdoes/>). DCSF.
- Department of Health (2009) What is Payment by Results? (http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4065236). Department of Health.
- Fombonne, E. (2002) Case identification in an epidemiological context. In *Child and Adolescent Psychiatry* (eds M. Rutter & E. Taylor), pp. 52–69. Blackwell.
- House of Commons Health Committee (1997) *Child and Adolescent Mental Health Services*. TSO (The Stationery Office).
- Meltzer, H., Gatward, R., Goodman, R., *et al* (2000) *Mental Health of Children and Adolescents in Great Britain*. TSO (The Stationery Office).
- Morley, D. & Wilson, P. (2001) *Child and Adolescent Mental Health: Its Importance and How to Commission a Comprehensive Service. Guidance for Primary Care Trusts*. YoungMinds.
- National Assembly for Wales (2001) *Child and Adolescent Mental Health Services: Everybody’s Business*. Primary and Community Healthcare Division.
- NHS Health Advisory Service (1995) *Together We Stand: Commissioning, Role and Management of Child and Adolescent Mental Health Services*. HMSO.
- NHS Health Advisory Service (1995b) A strategic approach to commissioning and delivering child and adolescent mental health services. In *Together We Stand: Commissioning, Role and Management of Child and Adolescent Services*, pp. 59–69. HMSO.
- O’Herlihy, A., Lelliott, P., Bannister, D., *et al* (2007) Provision of child and adolescent mental health in-patient services in England between 1999 and 2006. *Psychiatric Bulletin*, 31, 454–456.
- Rutter, M., Maughan, B., Mortimore, P., *et al* (1979) *Fifteen Thousand Hours*. Open Books.