

Child and Adolescent Mental Health
**TRAINING & DEVELOPMENT
PROJECT**

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THE INTERFACE BETWEEN FRONT-LINE STAFF AND SPECIALIST CAMHS SERVICES

**A Stream of the Child and Adolescent Mental Health Training
and Development Project**



Salomons

THE INTERFACE BETWEEN FRONT-LINE STAFF AND SPECIALIST CAMHS SERVICES:

PURPOSE OF THIS DOCUMENT:

The purpose of this document is to guide the group's thinking around the issues we will be discussing at the workshop on 19 May. The paper will attempt to look at current thinking in terms of the interface between primary and secondary care in child and adolescent mental health. It will attempt to explore some of the models proposed for this working relationship. The paper will also try to provide some of the local context at this point. Although there is not a lot of evidence for choosing between models a selection of projects will then be described to illustrate the possibilities. Hopefully this will enable us to focus our thinking on the relationship between the Specialist CAMHS team at Gatland House and frontline workers, particularly the community practitioners from the Maidstone/ Weald PCT, the Family Liaison Officers and the workers from the Family Centre in Maidstone.

In order for all of us to have a base level of shared understanding for the day I have put down some ideas around the area we will be focusing on. I will also attempt to clarify the use of certain terms and models.

DEFINITIONS:

There has been a lot of debate about the terms CAMHS. The Child and Adolescent Training and Development Project, following the lead from Child and Adolescent Mental Health: Everybody's Business (National Assembly for Wales, 2001) and Wolpert & Wilson (2003), makes a distinction between **Specialist CAMHS** and **CAMHS**. The concept of **CAMHS** for the project is inclusive, that is the term is taken to mean all of the services, provided by all sectors, that impact on the mental well-being, mental health, mental health problems and mental disorders of children and young people. In adopting this view some services will be brought into the CAMHS arena, on the basis of their ability to influence young people's mental health that previously, had not considered themselves to be within this field. Commonly, the term CAMHS is taken more narrowly to imply those specialist services provided, mainly but by no means exclusively, by the NHS. For the purpose of this document the term '**CAMHS**' refers to the whole enterprise and includes services that do not have mental health or providing for children as their only or key tasks. Some refer to this as '**comprehensive CAMHS**'. The term '**Specialist CAMHS**' will be used to refer to those multidisciplinary services that have a particular role and specialist expertise relating to child and adolescent mental health.

For the purposes of this document we will be referring to the four-tier model of child and adolescent health (CAMH) services proposed by the NHS Health Advisory Service (HAS) (1995). (Appendix 1 lays out how this tier system is structured and what the role and function of each tier is). The term '**frontline worker**' will refer to those working at Tier 1.

CONTEXT:

Child and adolescent mental health is being recognised as a key area of need. Psychiatric disorders are common and present in about 10% of children and young people in the general population (Bradley, Kramer, Garralda et al., 2003). However, there is a significant discrepancy between the prevalence rates for diagnosable disorders and the proportions of children and adolescents who access specialist services (Clarke, Coombs & Walton, 2003). Furthermore even well resourced Specialist CAMHS Units can only provide for a small proportion of the individuals and this help is focused upon established mental health problems, services still have an emphasis on response to rather than prevention of crisis (Audit Commission, 1999).

There is patchy development of Tier 2 services across the country and as a result of this, many children whose needs do not meet the criteria of a Tier 3 service, and should ideally be seen within a Tier 2 service, are not being offered treatment (Johnston & Titman, 2004). Many of these children and young people present to primary health, education and social services (Tier 1 according to the definitions in the HAS Report) (Bernard & Garralda, 1995; Kramer & Garralda, 2000). It is expected that expertise in the psychological and social aspects of children's mental health should be an intrinsic part of the work of these agencies (HAS, 1995). There is in fact evidence that many children with behavioural and emotional difficulties are managed in non-psychiatric setting (Burns, Costello, Angold, Tweed, Stangl, Farmer & Erkanli, 1995). The HAS report stresses the importance of informed awareness of child and adolescent mental health problems amongst the widest range of people working with children. One of the challenges of working with children and young people who have mental health problems often revolves around the front-line workers lack of confidence in dealing with mental health issues. This is because child and adolescent mental health has not been included comprehensively in pre-registration training courses, although some now address this area (Hooten, 1999). Frontline workers need to develop skills and experience in working with children, adolescents and families. This would help to address the early manifestation of emotional and behavioural difficulties. Recent national documents advocate the provision of early intervention services, one element of which is the support of Tier 1 workers in their developing mental health role.

Frontline professionals are faced with multiple demands on their time and an increasingly time-consuming agenda concerned with improving quality of care in several areas, including mental health. They require clear advice and assistance on ways of implementing improvements in primary care services so as to meet the aspirations of documents such as the National Service Frameworks. It has long been recognised that reinforcing the effectiveness of the child mental health care provided by primary services through interface or joint working is one of the tasks of secondary specialist CAMHS (Bradley et al., 2003).

It needs to be emphasised it is not only the fact that Specialist CAMHS would be overwhelmed if all children experiencing mental health problems were referred to them. Referral can be a damaging process and such a medical way of dealing

with these problems is generally not in the best interest of the young person. By developing the skills of frontline workers children and young peoples' emotional well-being can be promoted, mental health problems prevented from developing and where there are problems a non-stigmatising setting can be provided to deal with it. However it is also not always clear what problems can be managed at Tier 1. Joint working would thus contribute to greater communication, collaboration and shared understanding of roles at Tier 1 and with the other Tiers, all of which is crucial to providing a better service to young people and their families.

The Local Context:

A report ***The Interface: Primary Care and Secondary Mental Health Services (2002)***, was commissioned by the Primary Care Organisations in South of West Kent in collaboration with Invicta Community Care NHS Trust (Prior, 2002). The report constitutes the beginning of a dialogue between primary care and secondary mental health services.

The findings can be broadly summarised as follows:

- A keen interest in both primary and secondary care staff to work more closely in order to provide better-shared care for patients
- A need to develop capacity and capability within primary care to undertake mental health work with patients
- A need for greater support and liaison from mental health specialties staff for staff managing mental health problems in primary care across the spectrum of need
- A need for flexible, responsive, accessible and consistent services for patients
- A need for clear, regularly updated information regarding services and staff within the Mental Health and Social Care Trust and wider the community.

A primary care mental health training needs assessment was conducted by Prior (2003) on behalf of the Mental Health Joint Commissioning Board Dartford Gravesham and Swanley PCT. The findings can be broadly summarised as follows:

- Primary care staff show a high level of interest in mental health and are keen to develop their skills in this area of work, although some do not view mental health as directly relevant to their role.
- Training is requested in both familiar and novel areas of mental health work, demonstrating the need for updating and continuing support as well as for areas of development.
- Across the primary care workforce, many lack confidence in assessing or dealing with mental health presentations, although many are currently working hard to manage this increasing demand
- Primary care staff need current and realistic information regarding the various sources of help for those presenting with mental health problems across the spectrum of need.

- There is a call from primary care for better liaison and communication and stronger working relationships across the interface with secondary mental health services, including support from specialist mental health staff for the mental health work undertaken within primary care.
- The importance of training initiatives responding to the specific demands of particular roles within primary care and maximising on the potential to learn and develop alongside other professional groups and partner agencies.

The Clinical Baseline Assessment of the Maidstone and West Malling Outpatient Team – Gatland House (Giles, 2003) describes several areas in which the team are working with other providers of health and social care. It does appear from the assessment that there is a need for this to become more formalised, with better co-ordination, structuring, recording and evaluation of these interface activities. The assessment also suggested that these activities could be extended. It is now to some possible models of joint working that we turn our attention.

MODELS OF JOINT WORKING:

The main models of joint working between specialist secondary services and frontline primary care has been outlined by several writers (Bower et al., 2001; Bradley et al., 2003; Gask, Sibbad & Creed, 1997). These models are as follows:

- 1) Specialist CAMHS staff working within primary care (the shifted out-patient model);
- 2) Specialist CAMHS staff supporting primary care frontline workers (the consultation/liaison model) which takes the form of the following three types of interface work: training and education, consultation and joint case-work;
- 3) the presence of child and adolescent primary mental health worker (PMHW) posts. The HAS Report (1995) has highlighted the role of the PMHW. These workers would seek to consolidate skills in the primary care team, liase between primary care and specialist providers about referrals, assess and treat children and adolescents in primary care (Neira-Munoz & Ward, 1998).

Consultation and liaison:

Several authors (Bower & Macdonald, no date; Gask, Sibbald & Creed, 1997; Richardson & Partridge, 2003) argue that the consultation-liaison model may be the most attractive, in that it links specialists with workers in primary care and has an explicit focus on improving the skills of frontline workers. Richardson & Partridge (2003) argue that consultation enables the development of an integrated tiered system, improves communication, provides a greater understanding of the roles of Specialist CAMHS by Tier 1 professionals and fosters more relevant referral patterns. The consultation and liaison offers an alternative to service provision young people and support for frontlines professionals. It provides a method of:

- Ensuring children and young people with mental health problems, and their families, are dealt with by those with whom they already have a relationship
- Reaching more children than could be seen by individual mental health professionals
- Increasing confidence and expertise among those dealing directly with young people and their families

(Richardson & Partridge, 2000)

Appleton (2000) describes a number of different types of consultation:

- (a) Informal ad hoc consultation initiated by primary care.
- (b) Client-centred consultation via regular meetings.
- (c) Consultee-centred consultation via regular meetings.
- (d) Consultation about organisational change.
- (e) Mediation by Specialist CAMHS 2 between primary care professionals regarding co-ordination of care.

Gask & Croft (2000) suggest a variety of other methods of liaison in addition to those suggested above:

- (a) Triage: Operating some form of triage system could, for example mean all referrals are first screened by the attached or linked CPN, health visitor or school nurse.
- (b) Link Workers: Assigning link workers to liaise directly with practices to set up better channels of communication, shared care protocols and practice-based education.

All of these various methods overlap and any consultation and liaison service may operate in more than one of these modes. There is no standard blueprint and services need to develop according local needs and preferences.

Bower & Macdonald (no date) point out that evidence for the effectiveness of consultation-liaison is limited. Bower et al. (2003) conducted a systematic review to examine the education and training of primary care professionals in CAMH, the effectiveness of interventions provided by primary care staff (such as GPs and health visitors), the effectiveness of interventions by specialists working in primary care, and consultation-liaison. Their conclusion was that generally, the available literature was very limited in quantity, scope and quality (see the executive summary from Bower et al., 2003) in Appendix 2 for more details). As they point out

although policy has highlighted the role of the primary care team in the further development of CAMH services, at present such developments cannot depend on a reliable base of evidence on which to make decisions. ... if the promise of evidence-based policy making and service development is to be realised, a significant research effort may have to be initiated soon, given the methodological complexities of work in this area and the need for long term follow-ups of the effects of interventions with children.

(Bower & Macdonald, no date, p. 14)

It will therefore be of vital importance that whatever form of interface is adopted that it is evaluated and reported on to add to the evidence base. Another issue to bear in mind is that this model does depend on the willingness of Tier 1 professionals to take on additional roles and responsibilities (Bower & Macdonald, no date). In spite of these limitations Gask & Croft (2000) offer the following when trying to support workers in Tier 1.

Ways of supporting and developing Tier 1:

Gask & Croft (2000) described the key steps in achieving change in primary care:

- (a) Identification of the evidence base. As noted above, the research literature in CAMH in primary care is very limited. However, this can be augmented by local needs assessments, experience from other successful projects, and national guidelines.
- (b) Bringing together the key players at a local level. This was one of the forms of consultation identified by Appleton (2000). Mildred et al. (1999) demonstrated how both sides at the interface could benefit from greater understanding of the context of their work and the problems that they face.
- (c) Local needs assessment. Experience in total purchasing projects in adult mental health indicated that needs assessments are sometimes based on professionals' conceptions of need, which may not always provide a full or accurate picture (Lee et al., 1999).
- (d) Involvement of service users. This is a significant challenge in relation to CAMH services. Although local involvement is to be preferred, some national publications have examined this issue and may be of use (Armstrong et al., 1999; Laws et al., 1999).

These authors caution that change may well be slow and should proceed in a stepwise fashion, sensitive to the barriers identified and available resources. Key barriers to development include the availability of funding, the low priority afforded to CAMH in primary care, variability in the attitudes and enthusiasm of primary care staff, pressures on the Tier 3 specialist services and the rapid pace of change in primary care associated with the development of PCTs and the new clinical governance agenda. Gask and Croft (2000) describe some of the key barriers associated with setting up a consultation-liaison service, which may have more general relevance for facilitating change in primary care. Important issues include:

- (a) what are the agendas and expectations of the key players? Is the change driven by frontline staff, dissatisfaction by specialist services, or are the concerns of specialist services (e.g. concerning workload) driving the agenda? Differing agendas were noted as a key problem in the National Primary Care Research and Development Centre's (NPCRDC) evaluation of total purchasing pilots and their attempts to deliver change in adult mental health services (Lee et al., 1999).
- (b) what is the history of co-operation? The development of relationships takes time without a significant history of co-operation over previous projects.
- (c) what resources and expertise are available now?

(d) what is the level of motivation for change? Again, the total purchasing evaluation noted the importance of key individuals leading change (Lee et al., 1999).

Various Projects Being Run:

A variety of projects that have attempted, in various ways to bridge the specialist/frontline or primary/secondary gap will now be explored. This is not an exhaustive list, but rather to give an overview of the types of projects being implemented.

- Clarke, M., Coombs, C. & Walton, L. (2003) School based early identification and intervention services for adolescents: A psychology and school nurse partnership. **Child and Adolescent Mental Health, 8(1)**, 34-39

A training and consultation (supervision) model was developed to respond to the needs of Tier 1 staff encountering vulnerable adolescents in a deprived inner city area of Birmingham. The aim was to support the school nurses' mental health role. This was a partnership between the clinical psychology service and the school health system. The model aimed to promote the school nurses' skills in supporting adolescents to solve their own problems by building trusting and respectful partnerships. The model for this training draws upon evidence based counselling and problem-solving approaches (Davis et al, 1997; Egan, 1990). The specialist training consisted of 2 days, which built on the foundations of previous training (a university accredited three-day basic counselling course and two days' core school health training provided by the department of clinical psychology). The content of the specialist training included a six-point strategy:

1. recognition of emotional difficulties as distinct from normal stages of development
2. understanding of three clinical areas – anxiety, depression and eating disorders
3. awareness and sensitivity to issues of cultural difference
4. application of a problem-management model adapted from Egan's Skilled Helper Approach (Egan, 1990)
5. collaboration and partnership between workers and psychologists developed from the Davis Parent Advisor Model (Davis et al., 1997).
6. skills based practice sessions

The supervision model (based on that of Hawkins & Shohet, 1989) took a group format and was offered by the clinical psychologists on a monthly basis. Issues covered in supervision were individual case, discussion, the application of the practice model, cultural issues, professional concerns e.g. child protection and decisions about referral to specialist services. This led to a representative from the Tier 3 Specialist CAMHS team joining one of the supervision meetings in order to discuss care pathways for adolescents.

The key component of this practice model was the involvement of front-line workers who have direct contact with young people, who are trained in evidence based counselling and problem solving approaches and who can access

specialist services when necessary. The strength of the project was the successful development and implementation of a training and supervision package for Tier 1 professionals for their enhanced mental health role. The school nurses regarded the model as educational, supportive and constructive. This has now been extended to further core training for the school nurses and taking practice further supervision.

The authors argue that the practice model described, if offered alongside other complementary school and community intervention (Wells, 2000) provides a means of offering effective; accessible and non-stigmatising early mental health support to children and young people.

- Richardson, G. & Partridge, I. (2000) Child and adolescent mental health services liaison with Tier 1 services: A consultation exercise with school nurses. **Psychiatric Bulletin**, 24, 462-463.

This article describes a consultation model for joint working between Tier 1 and Tier 3 workers. The consultation process offered an opportunity for discussion of specific cases, discussion of professional issues (e.g. the role of Specialist CAMHS, boundary setting, role definition) as well as a forum for more formal teaching on clinical areas of interest and relevance to the school nurse task (e.g. deliberate self-harm, ADHD, eating disorders) as well as issues of clinical management (e.g. working with difficult parents, managing school teachers' anxieties). The school nurses could also phone to discuss issues and seek advice and support between the sessions.

The aims of the consultation, agreed with the consultees, were to:

1. improve communication channels between Specialist CAMHS staff and the school nurses
2. develop guidelines for Specialist CAMHS liaison with schools
3. develop guidelines for managing young people after overdoses
4. develop guidelines for dealing with self-referrals to school nurses
5. develop guidelines for setting time limits
6. develop guidelines for making appropriate referrals to Specialist CAMHS Teams
7. understand the functional structure of Specialist CAMHS
8. clarify referral routes
9. learn how to understand and set boundaries
10. discuss issues around the mental health of young people
11. discuss young people referred to the school nurse
12. learn how to manage young mothers and their behaviourally disordered children
13. learn how to manage anxiety in ourselves and in the schools
14. learn how to deal with bullying
15. learn how to prioritise

An evaluation of the process after 6 months revealed that school nurses had acquired a better understanding of Specialist CAMHS services and some

confidence in managing young people who are experiencing mental health issues.

- Johnston, T. & Titman, P. (2004) A health visitor led service for children with behavioural problems, **Community Practitioner**, **77(3)**, 90-94.

This was the development of a service for children with 'common behavioural' problems that ran alongside an existing Tier 3 CAMHS Specialist service. This service offered short-term behavioural treatment to children and families who had been waiting to be seen by a Tier 3 CAMHS Specialist Service. It illustrates the way in which Specialist CAMHS worked with Health Visitors in terms of training in assessment, and treatment of behavioural problems. The pilot service evaluation demonstrated that it was effective in terms of reducing the severity of problems experienced by children and families and there was a high rate of satisfaction with the service. The article also emphasises the importance of joint funding and service review.

- Mitchell, G., Baptiste, L. & Potel, D. (2004) Developing links between school nursing and CAMHS. **Nursing Times**, **100(5)**, 36-39

This was a project initiated by Islington school nurses. It was a partnership between Specialist CAMHS and community practitioners for the prevention and early intervention of child and adolescent mental health problems. Because of the increased number of complex cases relating to emotional, behavioural and other difficulties the school nurses felt they needed to develop links with Specialist CAMHS and have access to appropriate training. The Specialist CAMHS education service did a consultation designed to look at the work of school nurses and their area of expertise, as well as to gain comprehensive understanding of the training needs of nurses in terms of emotional, behavioural and mental health issues. The nurses highlighted six problem areas for further training: emotional problems, psychotic symptoms, challenging behaviour, family/relationship difficulties, psychosomatic problems and self-harm and risk taking behaviours. This consultation raised the profile of and interest in mental health issues among nurses.

- Sinclair, R. & Raleigh, A. (2002) Developing competence in frontline staff to support young people who self harm. Unpublished.

This project emerged from the Surrey Child and Adolescent Mental Health Strategy. The primary aim of this project was to devise a more integrated and coherent approach to managing self-harm in young people. The project aimed to identify and meet the learning needs of Tier 1 professionals in the identification and management of the first presentation of self-harm by a young person and to provide a programme of learning opportunities to meet these needs. The project was a multifaceted learning and skill development programme, which had four phases:

- A conference 'Understanding self-harm, promoting self-esteem'
- A series of nine linked learning sets held over 6 months

- The production of resource packs for schools and representative Surrey agencies
- The establishment of a joint Surrey protocol for the management of self-harm

An evaluation of the project suggests that there were a variety of benefits from the project. These included:

- Putting self-harm on the Surrey map
- Generating enthusiasm
- Increased awareness and interest in the area
- Staff being more skilled
- Better help in crisis situations
- Better resources and information, especially for schools
- Established protocol for dealing with self-harm

- Pettitt, B. (2003) **Effective joint working between child and adolescent mental health services (CAMHS) and schools**. Mental Health Foundation, Research Report No. 412

This research report was conducted for the Department for Education and Skills to explore joint working between schools and Specialist CAMHS in England and identify ways in which it might be improved. The following is from the executive summary of the report.

It is increasingly recognised that to improve the ability of child and adolescent mental health services to provide effective care to children and young people, it is necessary to strengthen the support Specialist CAMHS provide to other services, such as schools. This requires multi-disciplinary teams and inter-agency working.

The research sought to:

- Identify models of joint practice between Specialist CAMHS and schools in relation to promotional work and early interventions for children experiencing mental health problems in school settings in England.
- Identify the theoretical, historical, contextual and other factors that have influenced these models.
- Explore the impact of local, social, cultural and economic factors on practice, and the impact of local and national policy.
- Identify which factors contribute, and which create barriers, towards effective practice of joint Specialist CAMHS and schools work.
- Explore effective practice issues within different models.

Key Findings

- The majority of Specialist CAMHS who responded to the survey did work with schools (89%); 81% with secondary schools, 76% with primary, 72% percent with special schools for children with emotional and behavioural disabilities and 52% in special schools for learning disabilities. 40% were also working in early years settings.
- There was a wide variety of practice and structures in the way the Specialist CAMHS worked with schools. The most common form of work was **consultation and support to school staff**, often on a case by case basis

with children referred to their service. They also provided consultation on behaviour, training and supervision to school staff, and contributed to health promotion activities. 70% of Specialist CAMHS provided **direct work with children**, included individual and group work in schools, assessment and observation. Many **worked with parents** in school settings, especially with early years and primary age children.

- Just over half the CAMHS who responded worked with Local Education Authorities. This included work with the educational psychology service, education welfare service and behaviour support services. The most intensive work was a joint integrated service, and secondments of staff

Issues in joint working: Models, structure and management

- All of the CAMHS in the case studies were based on a tiered structure. This reflects a commitment to inter-agency working and supporting Tier 1 services. The majority of the case study Specialist CAMHS teams were working closely with LEA support services to schools, and either running joint services or seconding staff.
- Factors that facilitated joint working were:
 - secondments between organisations;
 - being based in the same location;
 - flexibility of recruitment so that people moved between posts across organisations;
 - having a clear understanding of the different roles and expertise of members of staff;
 - having a clear rationale for working jointly which is shared with the team;
 - a commitment to joint working from all levels of the service;
 - joint working;
 - informal meetings, networking and team building.
- Key issues were **managing expectations** of the service, and being clear about referral criteria for schools, so that the service did not get overwhelmed with inappropriate referrals.
- Many of the projects outlined were receiving short-term funding and support from initiatives such as Health Action Zones, Education Action Zones, and Healthy School Standards. Some areas expressed concern about the long term funding for the work. Having pooled budgets across the services was felt to be very useful.
- **Different organisational and professional cultures** represent a challenge to joint working. This impacts on the relationship with children, the approaches to work and understanding of mental health issues, attitudes towards children's behaviour, information sharing and confidentiality, management and accessing services. The majority of these problems were being resolved by close joint working, good communication, and sharing policies.

- The **skills of workers and good communication** were key, including the ability to work flexibly, and creatively, being able to pool professional skills, confidence in their own skills and being approachable. The importance of knowing individuals was also stressed, which has implications for longer-term funding and staff retention.
- Other key issues were the ways of **sharing information on cases**; **confidentiality** issues were raised and different approaches to sharing information. **Spending time in school** by Specialist CAMHS staff was important as it increased acceptance and knowledge both of health and school staff. However, it was important for health staff to remain part of the clinical team and receive supervision.
- National policies that facilitated the joint working were the HAS policy 'Together we Stand', Quality Protects, Social Inclusion Agenda and the Children's Fund Grant Process. There were a range of initiatives that had been instrumental in facilitating and funding the work including Education Action Zones, Health Action Zones, Healthy Schools Initiative and On Track. Some policies constrained joint working, however, and some criticism was made of education policies putting pressure on children within schools.

Impact, Advantages and Disadvantages

Impact on children

Overall many respondents, especially school staff, acknowledged that joint working had resulted in an increase in children's **happiness and well-being**. There was a measurable improvement in **children's behaviour** in two of the services, and better peer relationships were identified by workers. Although rarely measured, workers identified links to improved **academic attainment**, as children were able to learn and were developing learning skills. Education staff identified impacts on **exclusion** of children as their behaviour changed, or that they were allowed thinking space before being excluded. This was not being measured formally by the interventions. Some examples of work with school phobics showed improvements in school **attendance**.

Impact on staff

Working more closely **increased awareness and learning between health and education staff**. Education staff felt they had increased access to mental health services and a greater understanding of the services available. Health staff reported having a greater understanding of the school context and the impact it may have on children's mental health, staff, and educational resources.

Impact on service delivery

Specialist CAMHS staff felt that they were accessing children who would not normally be reached and identifying children's problems early. The services were felt by staff to be more accessible to parents and children as they were physically easier to get to, less stigmatising and within children's own environment. Specialist CAMHS workers identified that they received more appropriate referrals. Some workers felt that services were improved as they could allocate more appropriately within teams and avoided duplication of work.

Disadvantages were seen to be that this way of working was more time consuming, the potential danger of duplicating work if it is not co-ordinated effectively, management problems, issues over information sharing and getting swamped with referrals. Also, practitioners working with schools felt pressured by high levels of expectation of the service.

- Bower, P., Macdonald, W., Sibbald, B., Garralda, E., Kramer, T., & Harrington, R. (2003) **Child and adolescent Mental Health Services (CAMHS) in Primary Care**. Report to the Department of Health.

A copy of the executive summary of the report is attached under Appendix 2.

What is happening in Kent?

Most of the Specialist CAMHS teams have made attempts at working with Tier 1 workers. This has taken a variety of forms. Most of the work is ad hoc and not well co-ordinated. It is also very much dependent on the goodwill of personalities within the organisations and often fall apart when those people move on. One of the tasks will be to access the variety of training modules and courses that have been developed for example there is the programme developed by staff from the Invicta Community Care Trust under the co-ordination of Dr Shamim Mahmud, ***Child Mental health Issues in primary Care: A training programme for health visitors***. It will also be useful to bring together developments from the different areas and share these examples of good practice.

Conclusion:

There is a significant gap between the potential of primary care services in CAMH and the current ability of those services to improve access and effectiveness in this area, when there are so many competing priorities. Significant advances have been made, and the results of ongoing research studies should further highlight effective methods of organising services in the future. However, the task for clinicians, managers and researchers remains significant. We have no option but to find ways of working more effectively with each other. There is no universal blueprint that can be applied. Although we are all working towards the same end, ensuring a better life for children and young people, there are many misunderstandings between the groups doing this. Setting up more effective channels of communication and sharing problems can begin to break down barriers. But it will take time, flexibility and tolerance to achieve change.

What is clear is that the need is great for support and joint working with Tier 1 Professionals. However the CAMHS Specialist Units need to be realistic. We must avoid trying to be overly inclusive and end up being overwhelmed by the need and rather focus on small but realistic goals and from that we can expand out. It is also important to acknowledge that this is part of a broader change process both in terms of service provision but also in terms of how Specialist CAMHS teams are defined and seen.

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APPENDIX 1: LEVEL OF NEED AND SERVICE PROVISION FOR CHILDREN AND ADOLESCENTS:

LEVEL OF NEED AND SERVICE PROVISION FOR CHILDREN AND ADOLESCENTS:

LEVEL OF NEED	TIER OF SERVICE
BASE LEVEL: ALL CHILDREN	UNIVERSAL PREVENTATIVE SERVICES
<p>LEVEL ONE NEED: Potentially vulnerable children, who require access to services to prevent the development of problems Mild emotional and behavioural difficulties or the early stages of disorders Many conditions are self-limiting but may cause considerable distress in the child and family, disruption in the classroom and child's learning. Specialist support is by professionals such as school nurses or consultant community paediatricians. Tier 1 services often undertake management problems in consultation with Tier 2 and 3. This usually entails a process of 'holding' the child or young person. Wallace et al. (1997) describes this level of service as being required for localities.</p>	<p>TIER 1: PRIMARY CARE SERVICES</p> <ul style="list-style-type: none"> • General Practitioners • Health visitors • School nurses • Social services • Voluntary agencies • Teachers • Residential social workers • Juvenile justice workers <p>Non-specialists provide CAMHS. They aim to:</p> <ul style="list-style-type: none"> • Identify problems early in their development • Offer general advice and in certain cases treatment for less severe problems • Pursue opportunities for promoting mental health and preventing problems
<p>LEVEL TWO NEED: Vulnerable children who require further assessment of their needs</p> <p>LEVEL THREE NEED: Vulnerable children who require an immediate, short-term response</p> <p>Common disorders with one or two risk factors. Services offer expert assessment of the mental health aspects of child and family problems, treatment or referral. Problems that require Tier 2 services are not usually complicated by co-morbidity or serious risk factors and can be managed by health professionals with relevant skills and experience.</p>	<p>TIER 2 INDIVIDUAL SPECIALIST OR UNI-PROFESSIONAL CARE</p> <ul style="list-style-type: none"> • Clinical psychologists • Paediatricians, especially community • Educational psychologists • Child Psychiatrists • Community child psychiatric nurses/nurse specialists • Child psychotherapists. <p>CAMHS professionals would be able to:</p> <ul style="list-style-type: none"> • Offer training and consultation • Offer diagnosis and treatment • Offer consultation for professionals and families • Enable young people to benefit from their home, community education • Offer outreach to identify needs which require more specialist interventions • Offer assessment that may trigger treatment at a different tier.
<p>LEVEL FOUR NEED: Children with more complex needs and high levels of vulnerability</p> <p>Less common problems indicating a more severe, complex and persistent condition. Specialists should work closely with general paediatric and adult psychiatry services, local authority social services and education teams. Coordination of solo and multidisciplinary services can vary, two main models exist: Professionals collaborating in a multidisciplinary service that also provides solo service Multidisciplinary and solo professional services are organisationally distinct, but have mechanisms to collaborate effectively.</p>	<p>TIER 3 MULTIDISCIPLINARY TEAMS IN A COMMUNITY CHILD MENTAL HEALTH CLINIC OR CHILD PSYCHIATRY OUTPATIENT SERVICE</p> <ul style="list-style-type: none"> • Child and adolescent psychiatrists • Social workers • Clinical psychologists • Community paediatric nurses • Child psychotherapists • Occupational therapists • Art, music and dram therapists • Intensive psychoanalytic therapy • Family therapists <p>Services should be able to offer:</p> <ul style="list-style-type: none"> • Multi-professional assessment and treatment of mental health disorders • Assessment for referral to Tier 4 • Contribution to services, consultation and training at Tiers 1 and 2 • Participation in research and development (R&D) projects

<p>LEVEL FOUR NEED: Children with more complex needs and high levels of vulnerability</p> <p>Potentially severe disorders. Intensive and highly specialised care usually provided for older children and adolescents who are severely mentally ill or at suicidal risk. Services are provided at a supra district level and not all districts can expect to offer this level of expertise.</p>	<p>TIER 4 TERTIARY LEVEL SERVICES SUCH AS DAY CENTRES, HIGHLY SPECIALISED OUTPATIENT TEAMS AND INPATIENT UNITS</p> <p>Services include:</p> <ul style="list-style-type: none"> • Adolescent in-patient units • Secure forensic adolescent units • Eating disorder units • Specialist teams for sexual abuse • Teams for neuro-psychiatric problems <p>Tasks include:</p> <ul style="list-style-type: none"> • Assessment, treatment and management • Provision of interventions requiring such a high level of skill • Experience of working with rare conditions • Support to staff in other Tiers.
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(adapted from Enfield & Haringey NHS HIP (2001) Child and adolescent mental health services strategy and Hertfordshire Social Services Strategy documents and the HAS, 1995 Report)

APPENDIX 2: EXECUTIVE SUMMARY:

Bower, P., Macdonald, W., Sibbald, B., Garralda, E., Kramer, T., & Harrington, R. (2003) **Child and adolescent Mental Health Services (CAMHS) in Primary Care.** Report to the Department of Health.