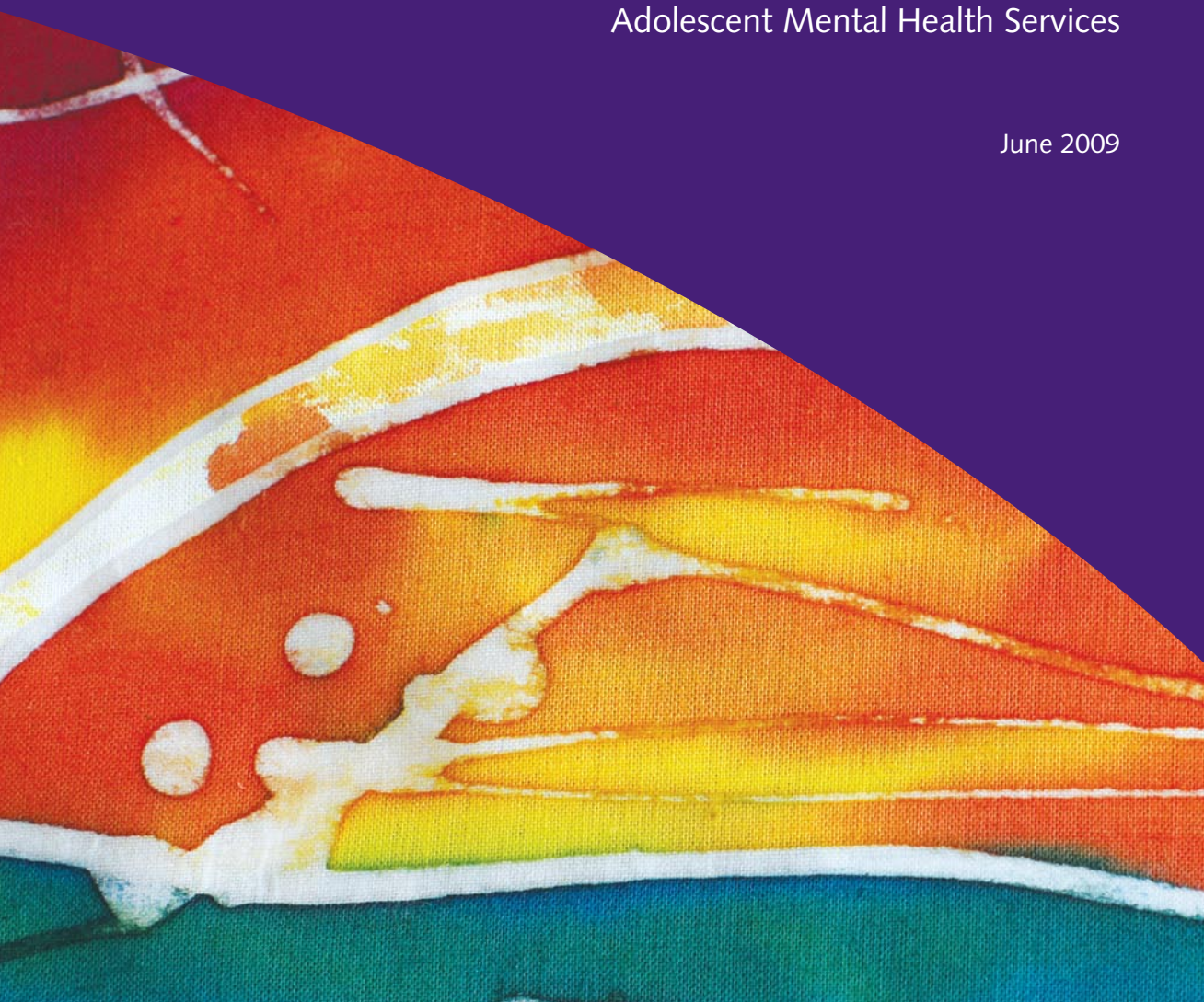


# **Working Together To Provide Age-Appropriate Environments And Services For Mental Health Patients Aged Under 18**

A briefing for commissioners of Adult  
Mental Health Services and Child and  
Adolescent Mental Health Services

June 2009



## DH INFORMATION READER BOX

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**For Recipient's Use**

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1. Mental Health Act 2007. [www.opsi.gov.uk/acts/acts2007/pdf/ukpga\\_20070012\\_en.pdf](http://www.opsi.gov.uk/acts/acts2007/pdf/ukpga_20070012_en.pdf)
  2. Mental Health Act 1983. [www.opsi.gov.uk/acts/acts1983/pdf/ukpga\\_19830054\\_en.pdf](http://www.opsi.gov.uk/acts/acts1983/pdf/ukpga_19830054_en.pdf)
  3. Department of Health (2008). Code of practice: Mental Health Act 1983. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084597](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597)
  4. Department of Health (1999). National Service Framework for mental health: modern standards and service models. [www.dh.gov.uk/assetRoot/04/01/45/02/04014502.pdf](http://www.dh.gov.uk/assetRoot/04/01/45/02/04014502.pdf)
  5. Department for Education & Skills, & Department of Health (2004). National Service Framework for children, young people and maternity services. [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT\\_ID=4089111&chk=U8Ecln](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/ChildrenServicesInformationArticle/fs/en?CONTENT_ID=4089111&chk=U8Ecln)
  6. UNICEF (1989). Convention on the Rights of the Child. [www.unicef.org/crc/](http://www.unicef.org/crc/)

## Foreword

This document is for commissioners of Adult Mental Health Services (AMHS) and Child and Adolescent Mental Health Services (CAMHS). It will also be of interest to other stakeholders, such as Children's Trusts, local authorities and providers of services, including those in the independent sector.


This briefing has been written to support commissioners to continue meeting the Ministerial commitment that from November 2008 no child under 16 is admitted to an adult mental health ward, and to assist them in making preparations so that the Ministerial commitment to commence section 31(3) of the Mental Health Act 2007 by April 2010 can be met.<sup>1</sup> Section 31(3) inserts a new section 131A into the Mental Health Act 1983.<sup>2</sup> It will ensure that patients aged under 18 are treated in an environment in hospital which is suitable having regard to their age (subject to their needs), with the purpose of preventing the inappropriate admission of children and young people to adult psychiatric wards. The briefing is based on the guiding principles that should be considered when making decisions under the Act. These are set out in Chapter 1 of the Code of Practice to the Mental Health Act, and include the requirement to use resources in a way which is 'effective, efficient and equitable'.<sup>3</sup>

The problem of young people with serious mental health problems being accommodated inappropriately on adult wards (and sometimes inappropriately on paediatric wards) is long standing and the new legislation gives statutory force to pre-existing government policy and guidance.<sup>4 5 6</sup>

We wish to encourage commissioners of both AMHS and CAMHS to work together to consider jointly their local services, and where appropriate redesign them to improve outcomes for young people. In many areas, this will have a beneficial impact on the demand for adult services and so have significant benefits in outcomes for both client groups and, in the long term, financial benefits for both services.

At the heart of this document is improvement in outcomes for young people and their families, supporting this very vulnerable group towards recovery and a future that allows young people to achieve their full potential.

We hope you will find it useful.

The image shows two handwritten signatures in black ink. The signature on the left is 'Jim Symington' and the signature on the right is 'Dawn Rees'.

**Jim Symington**, Head of External Commissioning and Improved Care Pathway Programmes,  
National Mental Health Development Unit (NMHDU)

**Dawn Rees**, National CAMHS Strategic Relationships and Programme Manager



# Chapter 1

## Introduction

The Government has pledged to bring the new section 131A of the Mental Health Act (MHA) 1983 into force in April 2010. This amendment will ensure that patients aged under 18 are treated in an environment in hospital which is suitable having regard to their age (subject to their needs), with the purpose of preventing the inappropriate admission of children and young people to adult psychiatric wards.

### How this briefing will help

This briefing highlights how commissioners can work together to meet the new duty on age-appropriate accommodation in a timely manner. Chapter 5 focuses on practical measures that commissioners can take within existing planning and commissioning cycles to effect change.

It is written in the context of the World Class Commissioning Programme,<sup>7</sup> the Department of Children, Schools and Families (DCSF) Commissioning Support Programme,<sup>8</sup> *Securing better health for children and young people through world class commissioning: A guide to support delivery of Healthy Lives, Brighter Futures: The strategy for children and young people's health*,<sup>9</sup> *World Class Commissioning: improving children's emotional health and psychological wellbeing*<sup>10</sup> and the Community NHS Contract Integrated Guidance,<sup>11</sup> all of which give full and detailed information to commissioners about the process of commissioning.

The Government is committed to safeguarding and promoting the best interests of children and young people. All organisations including those which commission and provide both Adult Mental Health Services (AMHS) and Child and Adolescent Mental Health Services (CAMHS) already have a duty under the Children Act 2004 to co-operate in improving children's well-being (s.10), including their physical and mental health and emotional well-being, and to make arrangements to ensure that care is provided 'having regard to the need to safeguard and promote the welfare of children' (s.11).<sup>12</sup>

7. The overriding objective of the world class commissioning programme is to transform the way health and care services are commissioned – adding life to years and years to life. World class commissioning will deliver better health and well-being, better care and better value for all. The WCC programme emphasises engaging public and patients, collaborating with clinicians and promoting innovation and improvement. [www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm](http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm)

8. Commissioning support programme for Children's Trusts [www.everychildmatters.gov.uk/strategy/planningandcommissioning/commissioningsupport/](http://www.everychildmatters.gov.uk/strategy/planningandcommissioning/commissioningsupport/)

9. Department of Health (2009). *Securing better health for children and young people through world class commissioning: a guide to support delivery of Healthy Lives, Brighter Futures: the strategy for children and young people's health*. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_094401](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094401)

10. Moss, J. (2008). *World Class Commissioning: improving children's emotional health and psychological wellbeing*. [www.cypf.csp.org.uk/silo/files/wcc-camhs-paper.pdf](http://www.cypf.csp.org.uk/silo/files/wcc-camhs-paper.pdf)

11. Department of Health (2008b). *Community NHS contract integrated guidance*. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_091451?1dcService=GET\\_FILE&dlD=183649&Rendition=Web](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451?1dcService=GET_FILE&dlD=183649&Rendition=Web)

Other policy documents, including the *United Nations Convention on the Rights of the Child*, described more fully in Annex 2, all emphasise the importance of joint planning to ensure that young people under 18 are treated appropriately and in a timely fashion, and stress that adult wards are not an appropriate environment for most under 18s. More recently, an independent review of CAMHS (supported by officials from DCSF and the Department of Health) was published in November 2008,<sup>13</sup> which highlighted the importance of integrated care for young people with severe mental health problems, with a particular emphasis on transition.

## Where are we now?

As this briefing explains (see chapter 3), at present, commissioning models and practice vary across the country. In those areas where under 18 year olds do end up on adult wards, either because there are not enough local CAMHS beds, or because the community-based services needed to support them to stay at home are not in place, AMHS commissioners are already purchasing services for those young people by default. Both AMHS and CAMHS commissioners need to come together to lead their local area to improve services in accordance with the *National Service Framework for Children, Young People and Maternity Services* and eliminate inappropriate use of adult wards in line with their obligations to meet the new statutory duties.<sup>14</sup> It is essential that commissioners take the lead in showing that this problem is one for all involved to resolve together.

This briefing has also highlighted key points of information in text boxes throughout the chapters. The key for these is below:

### Questions for commissioners

A series of key questions in each chapter for commissioners.

Products developed by the Mental Health Act 2007 Implementation Programme to help you.

Case studies

This briefing includes a Frequently Asked Questions Section (page 35 ) and an Action Checklist to help commissioners determine their local state of readiness (page 37).

12. Children Act 2004. [www.opsi.gov.uk/acts/acts2004/pdf/ukpga\\_20040031\\_en.pdf](http://www.opsi.gov.uk/acts/acts2004/pdf/ukpga_20040031_en.pdf)

13. Children and young people in mind: the final report of the National CAMHS Review (2008). [www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf](http://www.dcsf.gov.uk/CAMHSreview/downloads/CAMHSReview-Bookmark.pdf)

14. Department for Education & Skills, & Department of Health (2004). Op. cit.

# Chapter 2

## The change in legislation

*This chapter sets out the legislative context within which the new duty to provide an age-appropriate environment is due to come into force in April 2010.*

### The Mental Health Act and the new duty

Section 31 of the Mental Health Act 2007 amends the Mental Health Act 1983 by inserting a new section 131A.<sup>15 16</sup> The new section 131A applies to all children and young people who are in hospital for treatment for mental disorder, whether they are detained under the Act or admitted informally.

It requires managers of hospitals to ensure that:

*the patient's environment in the hospital is suitable having regard to his age (subject to his needs).*

What this means is set out in chapter 36 of the Code of Practice (revised 2008) to the Mental Health Act 1983.<sup>17</sup>

*This means that children and young people should have:*

- *appropriate physical facilities*
- *staff with the right training, skills and knowledge to understand and address their specific needs as children and young people*
- *a hospital routine that will allow their personal, social and educational development to continue as normally as possible*
- *equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.*

#### Questions for commissioners

Are assessment protocols in place to ensure every under 18 year old is assessed appropriately?

**What are the arrangements for out of hours assessments?**

What arrangements have been made to meet the physical, therapeutic and social needs of under 18s in all inpatient environments, planned and emergency, NHS and independent sector?

15. Mental Health Act 2007. Op. cit.

16. Mental Health Act 1983. Op. cit.

17. Department of Health (2008). Op. cit.

The legal framework for under 18s is complex. The National Institute for Mental Health in England (NIMHE) has produced guidance for professionals about admission and treatment of under 18s.

*The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorder: A Guide for Professionals* is available to download, and free copies have been made available to provider trusts. [www.nmhdu.org.uk](http://www.nmhdu.org.uk)

Section 131A also states:

*For the purpose of deciding how to fulfil the duty... the managers shall consult a person who appears to them to have knowledge or experience of cases involving patients who have not attained the age of 18 years which makes him suitable to be consulted.*

The Mental Health Act Code of Practice states that although the duty to provide age-appropriate accommodation is expected to be in force from April 2010,<sup>18</sup> hospital managers should take all the steps they reasonably can to comply with the duty before it comes into force.

There is also an expectation that those responsible for the treatment of under-18s should be child specialists.

*Where possible, those responsible for the care and treatment of children and young people should be child specialists. Where this is not possible, it is good practice for the clinical staff to have regular access to and make use of a CAMHS specialist for advice and consultation.*

The amended Act has already introduced new duties for PCTs to inform local authorities in advance and the courts (when asked) about beds that have been, or could be, commissioned for children and young people.<sup>19</sup>

The Guiding Principles in the Code of Practice also requires that:

*People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.*

18. Department of Health (2008). Op. cit.

19. See sections 140 and 39 of the Mental Health Act 1983 as amended by section 31(4) and (3) of the Mental Health Act 2007 respectively.

Furthermore, a commitment to end inappropriate admissions to adult wards for children under 16 from November 2008 was made by ministers in November 2007.<sup>20</sup> Chief Executives were reminded in December 2008 that no under 16 was to be placed on an adult mental health ward.<sup>21</sup> If under 16s are admitted to adult psychiatric wards this should be reported by the PCT and the provider to the Strategic Health Authority, with robust plans to prevent this from recurring.

#### Questions for commissioners

Have you contacted your Director of Children's Services and providers of out of hours rota such as the Adult Team or Approved Mental Health Professional team and given them appropriate information about bed availability, protocols for the admission of under 16s to prevent any admission to adult wards and protocols for 16 and 17 year olds?

**Are you monitoring your providers, including Foundation Trusts and highly specialist services such as Eating Disorder Units and reporting any incidents of under 16s on adult psychiatric wards (accommodated with over 18s) to your Strategic Health Authority as a Serious Untoward Incident, and agreeing clear action plans which demonstrate what steps have been taken to prevent recurrence?**

The wording of the Act allows for circumstances in which the adult ward may be considered the best place for a young person. Although the default position for commissioners and providers is that a CAMHS bed is normally preferable, sometimes a young person has to be placed on an adult ward, either because an overriding need to keep them safe requires immediate admission and an adult ward is the only place available, or (more rarely) because an adult ward is the most appropriate place to meet that young person's needs. In such circumstances, commissioners and providers need to be sure that the right safeguards are in place to ensure young people's welfare and safety.

The new duties are entirely compatible with previous legislation and policy, namely the Children's Acts, The National Service Framework (NSF) for Adults of Working Age, The NSF for Children and Maternity, Safeguarding Children and the CAMHS Review – see Annex 1 for more details.

20. Department of Health (2007). Government invests £31 million in children and young peoples' Psychiatric wards. <http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=330418&NewsAreaID=2&NavigatedFromDepartment=True>

21. Department of Health (2008). Treatment of younger people on adult psychiatric wards The Week, 69, 24-30 October 2008. [www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/theweek/DH\\_089721](http://www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/theweek/DH_089721)

Questions for commissioners

When an under 18 year old is placed temporarily on an adult ward where there is an overriding need to admit and no CAMHS bed is available, are arrangements in place to transfer the young person quickly to an appropriate placement?

**Is the Local Safeguarding Children's Board satisfied with the measures in place?**

Is the Strategic Health Authority aware of your plans?

**Have you written quality standards for adult psychiatric wards into your contract?**

The Royal College of Psychiatrists Research and Training Unit has developed a series of standards. The Safe and Appropriate Care for Young People on Adult Wards can be found on the College website within the Clinical and Services Standards section and will form part of the accreditation for Adult Acute Inpatient Mental Health Services (AIM) standards [www.rcpsych.ac.uk/clinicalservicesstandards.aspx](http://www.rcpsych.ac.uk/clinicalservicesstandards.aspx)

# Chapter 3

## Commissioning age-appropriate environments and services – where are we now?

*This chapter looks at how well the system is working at present. In particular, it considers variations in commissioning models around the country, what we know about the numbers of bed places and inappropriate placements on adult (and paediatric) wards, access to 24/7 services and emergency care, and staffing.*

Over the last four years, many areas have used the impetus from the NSF for Children and Maternity Services,<sup>22</sup> Every Child Matters<sup>23</sup> and PSA<sup>24</sup> targets for CAMHS, together with additional resources available to local authorities and PCTs to develop and expand care pathways for children and young people requiring mental health services. Additional capital funding (£31million nationally) was made available from central government specifically to prevent inappropriate use of adult wards by children and young people.<sup>25</sup> However, there is still wide variation in access and service models are poorly developed for inpatient and alternatives to hospital admission in some areas of the country.<sup>26</sup> The funding for the care of young people requiring mental health services is held in some places entirely within CAMHS budgets, in others with both CAMHS and AMHS inpatient budgets.<sup>27 28</sup>

### Commissioning models – a varied picture

Commissioning models vary across the country. Service providers have reported finding it difficult and confusing having to deal with a number of different commissioners when there are no clear agreed priorities for inpatient or intensive community treatment teams services, either locally or across the regions.<sup>29</sup> In some areas, services for 16 and 17 year olds are purchased by commissioners of services for adults of working age, rather than by

22. Department for Education & Skills, & Department of Health (2004). Op. cit.

23. Department for Education & Skills (2004). Every child matters: change for children. A range of publications are available at: [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)

24. H M Government (2008). PSA Delivery Agreement 12: improve the health and wellbeing of children and young people. London: HMSO [www.hm-treasury.gov.uk/d/pbr\\_csr07\\_psa12.pdf](http://www.hm-treasury.gov.uk/d/pbr_csr07_psa12.pdf).

25. Department of Health (2007). Op. Cit.

26. Kurtz, Z. (2007). Regional reviews of tier 4 child and adolescent mental health services: National CAMHS Support Service [www.cypf.csip.org.uk/silo/files/regional-review-of-tier-4-camhs.pdf](http://www.cypf.csip.org.uk/silo/files/regional-review-of-tier-4-camhs.pdf)

27. Singh, S. P., Evans, N., Sireling, L., & Stuart, H. (2005) Mind the Gap: the interface between child and adult mental health services *Psychiatric Bulletin*, 29(8), 292-294.

28. YoungMinds (2006) A Call to Action: commissioning mental health services for 16-25 year-olds. [www.youngminds.org.uk/publications](http://www.youngminds.org.uk/publications)

29. Kurtz, Z. (2007). Regional reviews of tier 4 child and adolescent mental health services: National CAMHS Support Service [www.cypf.csip.org.uk/silo/files/regional-review-of-tier-4-camhs.pdf](http://www.cypf.csip.org.uk/silo/files/regional-review-of-tier-4-camhs.pdf)

commissioners of children's services or CAMHS. Some organisations view 16 year olds in work as adults and so provide care through adult community teams and placements on adult hospital wards; young people of the same age who are still in full-time education, on the other hand, are considered still to need a CAMHS bed.

Elsewhere, the policy of placing the care and treatment of 16 and 17 year olds within CAMHS instead of AMHS (as recommended by the NSF for Children and Maternity Services)<sup>30</sup> has led to some tensions because the adult mental health service for this age group has been withdrawn but without any equivalent transfer of resources to the CAMHS.

Commissioners of AMHS and CAMHS are working collaboratively in some areas, however, and have set up a consortium arrangement, usually with one PCT acting as lead commissioner. In other areas, services are commissioned by specialist commissioners on a regional basis, in line with the recommendations of the Carter Review.<sup>31</sup>

### Leigh House Hospital Day Services

Leigh House Hospital in Winchester is a 20 bed inpatient unit which provides assessment, treatment and management of children and adolescents whose mental health problems and disorders cannot be managed in the community because of their complexity, risk, persistence and interference with social functioning and normal development. The principal aim of the service is to help young people improve their overall functioning level to a point where they are able to live in the community with the support of the referring health team, other involved agencies and their families/carers.

The service incorporates an innovative Adolescent Day Service which adds six places to the 20 inpatient beds. The Day Service acts as an alternative to inpatient admission or may also act as a step down from inpatient treatment, facilitating discharge to community services. The service works closely with colleagues in the community in managing the risks associated with young people with complex mental disorder and family problems. In appropriate cases it provides an effective alternative to inpatient treatment, maintaining the young person's links with family,

30. Department for Education & Skills, & Department of Health (2004). Op. cit.

31. The first Implementation Plan for Sir David Carter's Review of Commissioning Arrangements for Specialised Services in the NHS in England was published in November 2006, with a second phase version published in June 2007. This latest plan covers the next phase of changes, now that new structures have begun to bed down. [www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Commissioningspecialisedservices/DH\\_080941](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Commissioningspecialisedservices/DH_080941)

peer group and education. It is hoped that the service will reduce the length of stay for many inpatients thus freeing up beds and improving accessibility for new inpatients.

Leigh House is commissioned via a consortium agreement, managed by South Central Specialised Commissioning Group on behalf of 7 PCTs. PCTs fund the service on the basis of usage which is calculated on a 3-year weighted average basis with greater weighting for recent activity.

## What is the level of need for specialist community or inpatient services?

Research by Kim-Cohen et. al. identified that approximately 75 percent of adult service users have a diagnosis of mental disorder by the age of 18.<sup>32</sup> They found that young people who are at risk of or who develop severe and enduring mental health problems establish patterns of health behaviour and service use in adolescence which continues into adult life. The Christchurch Health and Development Study found that adolescents suffering from greater frequency of depression had more mental health and economic problems in later life.<sup>33</sup> The prevalence of mental health disorders rose sharply between 15 and 18 years.<sup>34</sup> In England and Wales, about 400, (5 per 100,000) 15 to 24 year olds take their own life each year.<sup>35</sup> 80 percent of psychoses start between 16 and 30, with 5 percent before the age of 15. 10 percent of service users with a diagnosis of psychosis commit suicide, usually in the first five years of onset, with highest risk at first relapse.<sup>36</sup> According to the World Health Organisation's World Health Report 2001, psychoses among young people is a major public health problem.<sup>37</sup> Worldwide, it ranks as the third most disabling condition and poses an enormous burden, both in terms of economic cost and of human suffering. The mean age of onset of psychotic symptoms is 22 with the vast majority of first episodes occurring between the ages of 14 and 35.<sup>38</sup> The onset of this disease is therefore often during a critical period in a person's development.

32. Kim-Cohen, J., Caspi, A., Moffitt, T. E., HonaLee., H., J., M. B., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, 60(7), 709-717.

33. Fergusson, D., Boden, J., & Horwood, L. J. (2007). Recurrence of major depression in adolescence and early adulthood, and later mental health, educational and economic outcomes. *British Journal of Psychiatry*, 191(4), 335-342.

34. Fergusson, D., & Horwood, L. J. (2001). The Christchurch Health and Development Study: review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry*, 35(3), 287-296

35. Office for National Statistics (2007). Mortality statistics: deaths registered in 2007 [www.statistics.gov.uk/downloads/theme\\_health/DR2007/DR\\_07\\_2007.pdf](http://www.statistics.gov.uk/downloads/theme_health/DR2007/DR_07_2007.pdf)

36. Care Services Improvement Partnership (CSIP) et al. (2007). GP guidance: emerging psychosis and young people: what you need to know. [www.iris-initiative.org.uk/silo/files/gp-practice.pdf](http://www.iris-initiative.org.uk/silo/files/gp-practice.pdf)

37. World Health Organization (2001). The World health report: 2001: mental health: new understanding, new hope. [www.who.int/whr/2001/en/](http://www.who.int/whr/2001/en/)

38. Department of Health (2001). Mental health policy implementation guide. London: Department of Health [www.dh.gov.uk/assetRoot/04/05/89/60/04058960.pdf](http://www.dh.gov.uk/assetRoot/04/05/89/60/04058960.pdf)

There is a strong association between mental health problems in adolescence and risk taking behaviour.<sup>39</sup> Young people are more likely to access mental health services in a crisis,<sup>40</sup> and for many that crisis is not met with age-appropriate inpatient or community care.

Research by the Royal College of Psychiatrists suggested in 2004 that approximately 1000 under 18s were admitted to adult wards per year,<sup>41</sup> a third of all under 18s admitted to psychiatric wards. In the previous voluntary notification scheme with Mental Health Trusts which ran from April 2003 to October 2006, the Mental Health Act Commission was notified of 1,308 under 18s detained on adult mental health wards, approximately 383 per annum. These figures also showed significant overrepresentation of young service users from black and minority ethnic backgrounds (BME), and particularly those from an African Caribbean background.<sup>42</sup> The Mental Health Act Commission, which has now migrated into the Care Quality Commission, has now reinstated its recording of young people detained under the Mental Health Act.

The *Count Me In* Census for 2008 reported 583 under 18s on psychiatric wards on the census day of 31 March 2008, with 48 young people on adult wards.<sup>43</sup> This is a huge improvement since the first survey in 2005, when 128 children and young people were on adult wards, and 7 on wards for older people.<sup>44</sup> *Count Me In* 2008 also recorded approximately 14 percent of under 18s as from BME communities.

39. British Medical Association (2003). Adolescent health. [www.bma.org.uk/images/Adhealth\\_tcm41-19549.pdf](http://www.bma.org.uk/images/Adhealth_tcm41-19549.pdf)

40. Street, C. (2000). *Whose crisis? Meeting the needs of children with serious mental health problems*. London: YoungMinds. [www.youngminds.org.uk/publications](http://www.youngminds.org.uk/publications)

41. Worrall, A., O'Herlihy, A., Banerjee, S., Jaffa, T., Lelliott, P., Hill, P., et al. (2004). Inappropriate admission of young people with mental disorder to adult psychiatric wards and paediatric wards: cross sectional study of six months' activity. *British Medical Journal*, 238(7444), 867-868. [www.bmj.com/cgi/reprint/328/7444/867.pdf](http://www.bmj.com/cgi/reprint/328/7444/867.pdf)

42. HL Deb 15 January 2007 c 550, 551 (Lord Patel of Bradford speaking at debate on Mental Health Bill) [www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70115-0013.htm#0701154400001](http://www.publications.parliament.uk/pa/ld200607/ldhansrd/text/70115-0013.htm#0701154400001)

43. Healthcare Commission (2008). *Count me in 2008: results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales*. [www.healthcarecommission.org.uk/\\_db/\\_documents/Count\\_me\\_in\\_census\\_2008\\_Results\\_of\\_the\\_national\\_census\\_of\\_inpatients\\_in\\_mental\\_health\\_and\\_learning\\_disability\\_services.pdf](http://www.healthcarecommission.org.uk/_db/_documents/Count_me_in_census_2008_Results_of_the_national_census_of_inpatients_in_mental_health_and_learning_disability_services.pdf)

44. Healthcare Commission (2005). *Count me in: results of a national census of inpatients in mental health hospitals and facilities in England and Wales*. [www.healthcarecommission.org.uk/\\_db/\\_documents/Count\\_me\\_in\\_census\\_2005\\_Results\\_of\\_the\\_national\\_census\\_of\\_inpatients\\_in\\_mental\\_health\\_and\\_learning\\_disability\\_services.pdf](http://www.healthcarecommission.org.uk/_db/_documents/Count_me_in_census_2005_Results_of_the_national_census_of_inpatients_in_mental_health_and_learning_disability_services.pdf)

### Brent – The Aspire Project for Young Black Males

In a partnership between the voluntary and statutory sector, Brent specialist CAMHS is assisted by Aspire to provide young black men of African Caribbean descent with culturally sensitive support to enhance emotional health and well-being, and to prevent hospital admission.

Using an holistic, intensive, mentoring approach with black workers providing positive role models to the young men, the workers are jointly trained by Aspire and CAMHS to:

- help the CAMHS team to increase their understanding of appropriate ways of working with young black men. The Aspire Co-ordinator sits in on case referrals, and is part of the assessment process, taking on clients/patients as appropriate
- support the young men to engage in treatment with the CAMHS clinicians, increasing the capability of mental health practitioners to engage with hard to reach black adolescent males and their families
- provide the young men referred to CAMHS with gender and culturally specific mentoring and other practical support such as accessing education and training; promotion of lifestyle skills; fostering social interests such as sports.

In its first year of operation the project diverted at least two inpatient admissions. Compared to the average unit cost of a hospital admission – £45k for an average 4-month adolescent inpatient admission in Brent – the project represented good value for money. The evaluation further highlighted:

- Support from black male mentors appears to enhance continued engagement with CAMHS and reduces stigma.
- The importance of male attachments and in normalising activities such as sports and education in reengaging and reintegrating young black males in society is clear.

### Inpatient resources

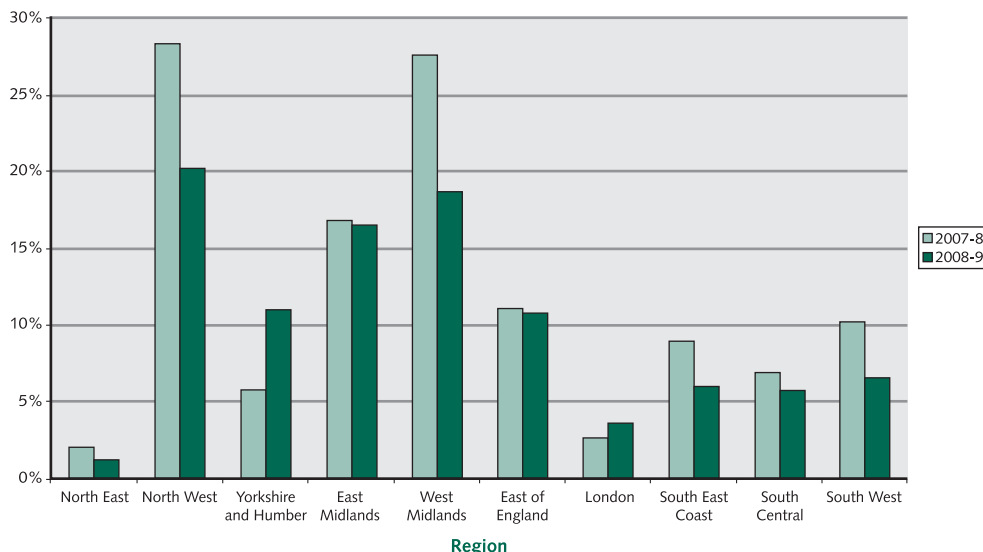
Although it has been government policy for some time to eliminate the inappropriate admission of under 18s to adult mental health wards, this still occurs in many areas of the country. This is due to a number of factors, including lack of access to inpatient CAMHS beds (eg North West<sup>45</sup>).

In 2007-8, the Local Delivery Plan Returns (LDPR) collected by the Department of Health showed that in England at least 10 percent of occupied bed days within NHS units for under 18s who require inpatient

45. Kurtz, Z. (2007). Op. cit.

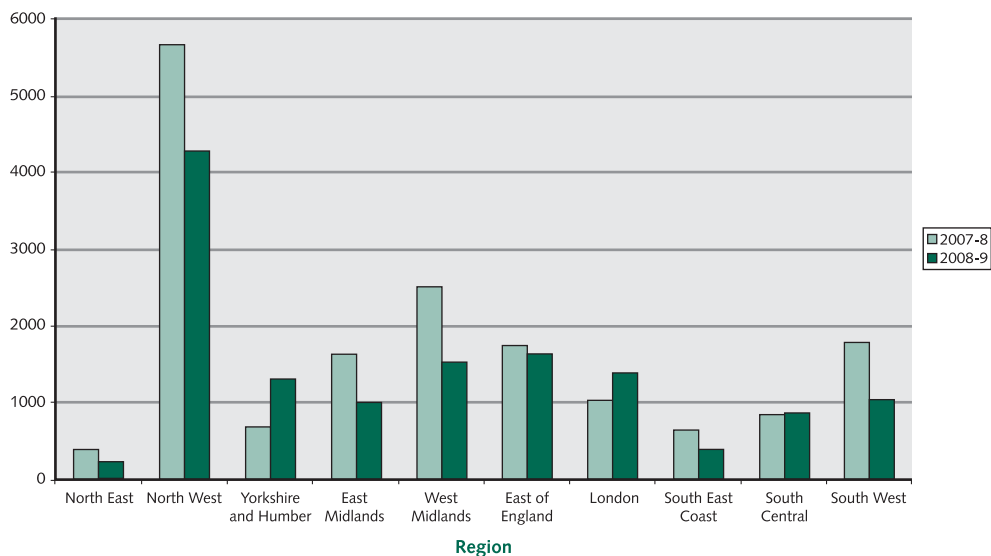
treatment for mental health problems were on adult wards. In some parts of the country, this percentage was as high as 28 percent. Figures for 2008-9 show an improvement, with 8 percent of occupied bed days provided by the NHS on adult mental health wards and reductions in several regions.<sup>46</sup>

**% Under 18s on Adult wards 2007-8 vs 2008-9 LDPR**



The numbers of occupied bed days on adult mental health wards by under 18s overall showed a decrease of over 3000 days over the same period.

**Occupied bed days under 18s on adult wards 2007-8 vs 2008-9 LDPR**



46. Department of Health. Local Delivery Plan Returns. 2007-8, 2008-9

In its annual report for 2006-07, the Quality Network for Inpatient CAMHS (QNIC) states that young people continue to have problems accessing appropriate inpatient mental health services.<sup>47</sup> More than half the units report insufficient beds matched to need for the locality. This sometimes leads to the use of adult or paediatric beds, or to patients being placed in age-appropriate accommodation out of their local area, with attendant problems of serious disruption to the young person's family and social life.

The figures for inpatient bed numbers given in national or even regional reviews can mask a near-total lack of provision in some regional areas. Activity reporting may indicate that one area has a very low number of children on adult wards, but this does not necessarily mean the local area has enough inpatient resources. It may reflect a high number of distant out-of-area placements. For example, London has almost three times as many beds as Yorkshire and Humber, so Yorkshire and Humber are far more likely to have to place young people out of their area. Many of the beds in London are purchased by other areas either due to their own shortages or because transport links to London make it easier for parents, families and friends to visit London than a rural unit within the region.<sup>48</sup>

Between 1999 and 2006 the independent sector accounted for 69 percent of the increase in bed numbers, and 36 percent of all beds by 2006 (up from 25% in 1999).<sup>49</sup> However, independent sector beds are also concentrated in London and the South-East, contributing to the regional imbalance. Moreover, while the costs of independent beds may be on a par with those provided by the NHS, there may be additional costs associated with resettling the young person back into their local community if they have been an inpatient some considerable distance from their home.

## 24/7 access and Emergency Care

Although there has been an improvement in delivering to mental health services for under 18s where the need is urgent or an emergency, evidenced by the returns from PCTs monitoring the relevant PSA Target, interpretation of the requirements detailed in the target is not consistent across the country.

47. Davies, G., & Thompson, P. (Eds.) (2008). The Quality Network for Inpatient CAMHS: annual report : review cycle 6: 2006-2007. London: Royal College of Psychiatrists' Centre for Quality Improvement. [www.rcpsych.ac.uk/pdf/QNIC%20Annual%20Report%20Cycle%206.pdf](http://www.rcpsych.ac.uk/pdf/QNIC%20Annual%20Report%20Cycle%206.pdf)  
QNIC is a network for in-patient child and adolescent mental health services, supported by the Royal College of Psychiatrists. Approximately 85-90% of units in the UK and Ireland are members. QNIC demonstrates and improves the quality of child and adolescent psychiatric in-patient care through a system of review against service standards. The process is supportive and enables information sharing between services that can sometimes be isolated.

48. Kurtz, Z. (2007) Op. cit.

49. O'Herlihy, A., et al. (2007). Provision of child and adolescent mental health in-patient services in England between 1999 and 2006. *Psychiatric Bulletin*, 31(12), 454-456.

Service models vary between full psychiatrist-first-on-call services and a range of professionals on call, with varying levels of co-operation with adult mental health services, A&E, paediatric services and local authorities.

### **In Time Bed Availability for CAMHS (ITBAC)**

Commissioners and referrers often spend many hours attempting to find inpatient places for children and young people who may need urgent help. Commissioners and referrers need access to up to date information about inpatient CAMHS services and their availability. In 2008 the National Inpatient Reference Group, chaired by the National CAMHS Support Service (NCSS) commissioned a new piece of work, to be undertaken by Quality Network for Inpatient CAMHS (QNIC) and co-sponsored by the Department of Health in partnership with NCSS. This pilot will develop inpatient service maps into an up to date interactive web based resource to enable local, regional, and specialist commissioners, and CAMHS professionals, to identify NHS and independent inpatient units in each region of the UK and their current bed availability. QNIC will maintain this site to ensure that the information is up to date and fit for purpose. The aim is to start a very simple service offering basic data and to then develop this according to feedback from those using it and a full pilot review. The pilot for ITBAC started in February 2009 and was scheduled to run for six months then be reassessed.

ITBAC data base will be publicly available at no charge to service providers or web users. [www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/qnic/itbac.aspx](http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/qnic/itbac.aspx).

The National CAMHS Support Services national review of inpatient and highly specialist strategies found that specialist community CAMHS that are well staffed and have good collaborative arrangements with adult mental health services frequently build effective 24/7 services, especially in rural areas. It found that CAMHS that are geographically close to CAMHS in-patient units offer the most consistent 24/7 crisis services because of the availability of on call psychiatrists. Very few inpatient services in England are currently commissioned or resourced to admit young people in an emergency out of hours.<sup>50</sup>

50. Rees, D. (2007). Learning perspectives from the National Child and Adolescent Mental Health Service Improvement Programme: National CAMHS Support Service [www.csip.org.uk/silo/files/ncss-learning-perspectives.pdf](http://www.csip.org.uk/silo/files/ncss-learning-perspectives.pdf).

Recent QNIC data suggests that although there has been an increase in appropriate provision in some areas, only 38 percent of units were able to admit young people at severe risk as an emergency, ie within 24 hours.<sup>51</sup> This is echoed by the research of Cotgrove et al.<sup>52</sup> QNIC report that there has been no real improvement in this area over the previous five annual cycles of peer review.

### Reducing the Burden of Self-Harm in Children in Hartlepool

The CAMHS team in partnership with the acute service at the local hospital has developed protocols and standards for practice around deliberate self-harm. If a young person presents at A&E with self-harm they will be admitted to the paediatric ward if they are under 16. If they are over 16, overnight admission for medical and mental health assessment is encouraged, but some young people refuse and decide to go home. A member of the CAMHS team, operating on a rota basis, will ring A&E each morning at 9.30am to enquire whether any young person has presented with self-harm during the previous 24 hours. If so, then within 24 hours a member of the team will visit the young person, whether in hospital or at home, in order to make an appropriate mental health or risk assessment.

Most young people are responsive but if the young person refuses to engage with the team, their GP is alerted and made aware of the issues. The team is also trying to bring school nurses into the loop by sending them discharge summaries so that schools are aware of the situation and can be supportive.

Services tend to be weaker in rural areas or where there are high staff vacancies, where there is no access to psychiatrists on-call or where partnership arrangements with the local authority's on-call service is not functioning well.

The NCSS National Review found there was a lack of available crisis beds for young people which had a negative impact on Out of Area Treatment payments, significantly inflated overspends in mental health trusts and PCTs.<sup>53</sup>

51. Davies, G., & Thompson, P. (Eds.) (2008). Op. cit.

52. Cotgrove, A. et al. (2007). The ability of child and adolescent units to accept emergency admission in England and Wales between 2000 and 2007. *Psychiatric Bulletin*, 31(12), 457-459.

53. Kurtz, Z. (2007). Op. cit.

### The Coborn Centre for Adolescent Mental Health

The Coborn Centre is an inpatient unit for children and young people aged 12-18. The unit has 14 inpatient beds, 3 of which are High Dependency allowing for emergency referrals of young people who previously may have been placed on adult mental health wards due to their complex presentation. With 6 day places and excellent liaison with community teams the unit offers the young people of East London a mixed model of care which can be adapted to offer highly individualised packages of care. The Centre works closely with local communities to address issues of stigma and fear on mental health services in general, and inpatient services in particular to encourage young people and their families to access care early rather than waiting till crisis point.

### Placements on paediatric wards

The reduction of inpatient beds for younger children with mental health needs has, in some areas, led to greater use of paediatric beds for children and young people with high levels of mental illness. It is possible that this trend may increase as areas strive to ensure that no young people are placed on adult wards.

Although the QNIC data collected was extremely sparse, there was a widely expressed view that children and adolescents with mental health problems admitted to paediatric wards could get a poor service. According to QNIC, staff were often not equipped to deal with these young people and had to rely heavily on specialist community support, which was often inadequate.<sup>54</sup>

#### Questions for commissioners

What is the inpatient provision in your area for under 18 year olds?

#### **What happens to under 18 year olds in an emergency?**

How often are paediatric wards or police stations used as an alternative to adult psychiatric wards?

#### **What happens to under 18s where the admission is planned?**

What out of area placements are used?

#### **What is the cost of emergency, planned, NHS and independent beds?**

How far do young people and their families and friends have to travel for treatment or to visit young people? How often can they visit, and does this affect discharge planning?

#### **What is the average length of stay for local placements versus distant placements?**

Is there a difference in how young people engage with local services if they have been placed far from home, and what effect might this have on readmission?

54. Davies, G., & Thompson, P. (Eds.) (2008). Op. cit.

# Chapter 4

## What do young people want?

*The imperative behind the changes in legislation and policy is to ensure that children and young people get the care they need, when they need it from the right people. Both World Class Commissioning<sup>55</sup> and the DCSF Framework<sup>56</sup> emphasise the importance of listening to children, young people and their families when designing service. This chapter looks at what we know, from national studies and other research, about what kind of services and care they most want and value, and how commissioners could apply this locally.*

Considerable work has already been undertaken nationally to discover the views of young patients and their families and carers about inpatient and community-based care.<sup>57 58 59</sup> In January 2007, the Children's Commissioner for England published a report *Pushed into the Shadows* based on consultations into the care experienced on adult wards by a sample of under 18 year olds. The report detailed a series of bleak, real life case histories which illustrated wards which were unsafe, where therapeutic interventions were unavailable or inappropriate for young people, discharge planning was poor or non-existent and young people experienced physical and verbal abuse and sexually inappropriate contact. *Whose Crisis* highlighted both the experiences of young people and of staff who were concerned that the ward was unable to offer a safe and therapeutic environment.

A follow-up report to *Pushed into the Shadows*, published more than 18 months later *Out of the Shadows?* identified seven core elements of care and support essential when planning, commissioning and delivering mental health care to young people.<sup>60</sup> Meeting these core elements will ensure that young people receive good quality, age-appropriate services that are responsive to their needs and delivered in a manner that respects and promotes their rights.

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55. World Class Commissioning. [www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm](http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm)

56. Commissioning support programme for Children's Trusts [www.everychildmatters.gov.uk/strategy/planningandcommissioning/commissioningsupport/](http://www.everychildmatters.gov.uk/strategy/planningandcommissioning/commissioningsupport/)

57. Street, C. (2000). Op. cit.

58. The Children's Commissioner for England (2007). *Pushed into the shadows: young people's experience of mental health facilities*. London: Office of the Children's Commissioner <https://http://www.11million.org.uk/resource/m8vtedhs9cbqx3aid5stkdrr.pdf>

59. Ines, G., Vasiliou, C., & Penketh, K. (2007). Listen up: person centred approaches to help young people experiencing mental health and emotional problems. London: Mental Health Foundation [www.mhf.org.uk](http://www.mhf.org.uk).

60. 11 Million, & YoungMinds (2008). *Out of the Shadows? A review of the responses to recommendations made in Pushed into the Shadows: young people's experience of adult mental health facilities* [www.11million.org.uk/resource/lokotpj40iak1voug7z7ejn.pdf](http://www.11million.org.uk/resource/lokotpj40iak1voug7z7ejn.pdf)

The seven areas are:

- i. a safe and supportive environment
- ii. provision of age-appropriate information
- iii. involvement in care planning
- iv. access to independent advocacy
- v. access to education
- vi. involvement in daily activities
- vii. opportunities for participation.

*Out of the Shadows?* identified and summarised the key messages to emerge from the various pieces of research into the wishes of young people using mental health services.

- Young people need to know how to access services when they need them, particularly in an emergency. The routes to services should be well publicised in places and by methods that are used by young people
- Young people need to know that they will be treated in a setting where they will feel at ease, i.e. not a children's clinic or somewhere where they will feel stigmatised
- Young people often appreciate the informality of a drop-in service, which may be less stigmatising for them among their peers
- It is essential that young people can trust the professional to respect their confidentiality wherever possible, and that they are made aware of information sharing policies. They need to know their families and carers will be supported and involved if appropriate, but that their confidentiality will be respected
- Young people want to be involved in decision making – not just about their own treatment, but also in the planning and development of services as a matter of routine
- Young people should feel they can influence their progress, both by their personal actions and by making their views known, for example, about whether or not a particular intervention is working
- Young people want to have choices in their treatment and their future clearly explained to them and to know that any intervention is focussed on recovery so that they have a future in the worlds of work or continuing education/training
- Young people may need help from several agencies, and prefer to have one worker co-ordinating all the help needed for them
- Young people need to know that any particular needs or issues relating to their culture, religion, gender or sexual orientation will be handled appropriately and without prejudice

- Young people want to know that, should they need longer term treatment or help, this will be handled in a way that is appropriate for the individual, rather than for the convenience of 'the system'
- Finally, they need to know that, should they need inpatient treatment, they will be treated in an environment which is appropriate for them as a person, rather than the decision being made solely on their age.

### Liverpool CAMHS Participation

The Liverpool CAMHS Partnership is committed to involving children and young people in CAMHS development at both the provider and commissioner level. The commissioning of CAMHS in Liverpool has been influenced by the needs of children and young people and this has resulted in the procurement of both specialist CAMHS and services within the third sector. Their model is:

- Children, young people and parents can access an e-mail and telephone system monitored through the PCT for feedback and advice about CAMHS in Liverpool. This is promoted on the CAMHS guides distributed across Liverpool to children and young people and parents/carers
- Support for providers in developing participation in their services
- Resource to Merseyside Youth Association (MYA) for Participation Officers to provide support for providers and the process
- Two boards/networks. One for children and young people and one for parents/carers. These will feed into the CAMHS strategic groups and regional networks. These have a clear purpose and agenda, and are children, young person and parent/carer led. The groups would also discuss any issues that were fed into the CAMHS e-mail or telephone system.

#### Questions for commissioners

How much do you know about what children, young people and their families think about the services you are offering?

**Do children, young people and their families know how to get help in an emergency?**

How involved are young service users and their families in planning future developments?

**Are there existing groups of young people you could contact to ask for help to assess your current service and plan for the future?**

Is there a local carer's group which could assist?

**If you do ask for the view of young service users and carers, what do you do with that information? How do you give them feedback about what you have done?**

# Chapter 5

## Getting ready for 2010 – meeting the new duty

*This chapter considers how commissioners of both AMHS and CAMHS can work together, using existing planning and commissioning structures, to ensure the new duty is met from 2010. In particular, it identifies a series of practical steps commissioners can take to ensure the right services are in place to meet children and young people's needs and avoid inappropriate inpatient placements on adult wards.*

Commissioners of both AMHS and CAMHS will already have their own commissioning arrangements in place and will have plans for developing their services. Collaboration between commissioners of AMHS and CAMHS to deliver services to meet the new duty in legislation may also benefit other areas of concern such as transition of young people to adult services.

### Working within the Local Strategic Partnerships

Local Strategic Partnerships drive change and service improvement. It is important that the Local Implementation Team (LIT)/Mental Health Partnership Board, which considers adult services, and the CAMHS Partnership Board should together lead the development of an integrated strategy for helping young people who need mental health services. Both boards will need to understand the local picture, including projections from public health colleagues about the future population and trends in service need, such as in different sectors of the area or in different ethnic communities. They should also be made aware of the research into the needs of young people, and in particular any examples of good practice in other parts of the country.

The aim of a joint strategic plan for young people with mental health problems will be to obtain the best possible services for this group, optimising the young people's life chances, while also maximising the resources available in both services, giving best value for money.

### **Worcestershire Early Intervention Psychosis Service**

Worcestershire Early Intervention Psychosis Service (EIS) offers early intervention to the full age range from 14-35 years. It has an EI CAMHS case manager post funded from CAMHS grant monies who offers dedicated case manager support to the under 18s. The team from adult services works in an integrated way with CAMHS colleagues in the support of under 16s and have a clear protocol as to how it works together across the age transition in the support of 14-16 year olds with first episode psychosis. The EI team sits on the CAMHS multi-agency steering group with colleagues from CAMHS, local authority, youth services and education.

The involvement of the LITS/Partnership boards, as cross-agency organisations, will ensure that all aspects of the young people's needs are considered, with services such as education and housing being made aware of the part they need to play in supporting this group, and giving their commitment to the plan.

LIT/Partnership boards will have to pay particular attention to identifying the resources currently within the system to see how this could be better used.

Sources of funding could be as follows:

- CAMHS inpatient beds – NHS and Independent
- AMHS inpatient beds – NHS
- One to one observation or 'specialing' costs. In many adult units the protocol for admitting an under 18 year old to the ward requires one or two nurses to accompany the young person at all times. The costs of this can be high, particularly if the young person has a protracted stay. These costs may be hidden in Trust Bank costs and not immediately apparent. If an under 18 year old stayed for a month on an adult ward and received one to one observation from an agency nurse for 24 hours a day, and if the cost per hour was £25, the cost of specialing would be £18,000 which is in addition to the occupied bed day cost. Many independent units also charge extra for one to one nursing.

Questions for commissioners

Do you need a fresh needs assessment, for example, to establish figures for those currently in the services, including presenting problems, diagnoses, treatment and outcomes?

**Has there been any clinical caseload analysis to consider whether some admissions could have been prevented, or the length of stay reduced, if a dedicated service for young people had been available?**

Have any young people been admitted inappropriately to an adult ward?

**What are the resources currently used on inappropriate placements, whether on adult wards with high-agency costs or on high-cost spot purchasing of out-of-area placements in independent Tier 4 units, or through the placement of young people with mental illness on paediatric wards?**

Are there particular areas of concern at the transition period?

**What happened to those young people who were referred to mental health services but did not attend appointments or who refused the service? Were there specific issues which deterred them, which could be remedied to prevent young people from waiting until there is a crisis before engaging with services?**

Do you know what young service users and their families think? (see Chapter 4)

## Doing things differently – learning from innovative practice

Unlike Adult Mental Health Services, where planning and service development has been guided by the Mental Health Policy Implementation Guide (MH PIG)<sup>61</sup> the development of CAMHS is subject to greater levels of local variation. The *NSF for Children, Young People and Maternity Services*<sup>62</sup> described the development of a comprehensive CAMHS and what its features might be, without the service composition templates within the MH PIG. As a result, there is considerable variation in service models and practice, but this gives an opportunity for commissioners who wish to change their service models and configuration to identify with providers and other stakeholders as to which solution would be best suited to local needs.

There are particular services working in a holistic manner with service users and their families that have drawn from the psychosocial inter-agency way of working that characterises many CAMHS teams. They may have combined this with outreach to develop services that have delivered real improvements in outcomes for their service users, enabling many to stay well or to maintain treatment in the community rather than depend on inpatient services.

61. Department of Health (2001). Mental Health Policy Implementation Guide. London: Department of Health [www.dh.gov.uk/assetRoot/04/05/89/60/04058960.pdf](http://www.dh.gov.uk/assetRoot/04/05/89/60/04058960.pdf)

62. Department for Education & Skills, & Department of Health (2004). Op. cit.

Based on the available evidence, McDougall et. al. identified the following as key components of intensive community treatment:<sup>63</sup>

- *Treatment at home or reduced length of stay in hospital*
- *Small caseloads*
- *24 hour rapid response*
- *Multi modal treatment strategies*
- *Close involvement of partner agencies*
- *Individually tailored treatment*
- *Flexible working practices*
- *Systemic basis*
- *Strong partnership with young person and their family or carers*
- *Prevention of family breakdown.*

In some areas, the development of EIP teams has already set AMHS and CAMHS commissioners on the road of joint commissioning, as they considered how best to use the teams to support young people. The aim is to reduce mortality rates from suicide and undetermined injury substantially by 2010 (by at least 20 percent from the *Our Healthier Nation* baseline, 1995 –1997).<sup>64</sup> However, in other areas EIP teams have increased the lower age threshold from 14 to 16 or 18, leaving gaps in services for some young people.

### **Bradford Early Intervention Psychosis Service**

In Bradford the care of children with a first episode psychosis is provided by the Bradford & Airedale EI service in partnership with the local CAMHS teams. Adult and children's commissioners (PCT) have jointly funded 1.5 whole time equivalent mental health nurses with backgrounds in child and adolescent mental health. The service also receives funding from substance misuse commissioners and the local authority. The Bradford EI service is a hub and spoke model and the CAMHS workers exist as one of 4 spokes, with the capacity to look after up to 15 children. They are managed by the EI service but work closely with CAMHS, coordinating specialist input from CAMHS psychiatrists and psychologists. EI CAMHS workers in Bradford assess and care-coordinate 14-16 year olds predominantly but will accept referrals below this age.

63. McDougall, T. et al. (2008). Tier 4 child and adolescent mental health services (CAMHS) - inpatient care, day services and alternatives: an overview of tier 4 CAMHS provision in the UK. *Child and Adolescent Mental Health*, 13(4), 173-180.

64. H M Government (2007). PSA delivery agreement 18: promote better health and wellbeing for all. Retrieved from [http://www.hm-treasury.gov.uk/d/pbr\\_csr07\\_psa18.pdf](http://www.hm-treasury.gov.uk/d/pbr_csr07_psa18.pdf)

Early interventions, whether at times of crisis or at the outset of an illness can lead to improved outcomes for young people and consequently to reducing the numbers of young people who will continue to need mental health service.<sup>65</sup> This in turn could reduce the need for inpatient treatment for young people, and thus help towards easing the pressure on age-appropriate accommodation.

For commissioners, the April 2010 deadline provides both the impetus and an opportunity to stand back and analyse how both CAMHS and AMHS are working, and to consider the strengths and weaknesses of current provision.

The evidence suggests that a 'mixed economy' of inpatient places and other non-bed based community services is the most effective in meeting young people's needs.<sup>66 67</sup>

### **The Community Intensive Treatment Team, South Wales**

The CITT was created in 1998 to serve young people who needed more care than was possible in conventional outpatient clinics as it became apparent that many of these cases were being lost to the system or needed admission to psychiatric units far distant from young people's homes or into adult wards. The team works on multi-systemic therapy principles, providing motivational interviewing / engagement, and as appropriate – family therapy, behavioural therapy, cognitive therapy, medication, networking, health education and social services. The team has found that their work blends well into family life, leading to better outcomes for the young person. Under 10% of the young people cared for by the team go on to need admission to an adolescent inpatient unit, but continued support by the CITT ensures that young people have a safe and appropriate discharge as soon as possible back home. Young people may be cared for by the CITT for up to a year. The costs of providing intensive community support for the majority of young people are much less than the equivalent inpatient stay.

Areas may consider a mixed model of care for young people in a crisis, developing emergency beds as well as crisis intervention or home treatment teams to maintain some young people in the community. Alternatively, CAMHS have been involved in adult crisis teams to enable the team to support older adolescents. This gives the opportunity to ensure that there is flexibility within services so that individuals' needs can be considered in their entirety,

65. CSIP Northwest & CSIP West Midland (2007) Early detection and intervention for young people at risk of psychosis <http://earlydetection.csip.org.uk/silo/files/feb-2008-early-detection-report.pdf>

66. Lamb C. et al.(2008) Working at the CAMHS/AMHS Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults [www.rcpsych.ac.uk/pdf/Transition\\_2008.pdf](http://www.rcpsych.ac.uk/pdf/Transition_2008.pdf)

67. McDougall, T. et al. (2008). Op.cit.

rather than having the patient pathway determined by the young person's chronological age alone.

A number of developments in AMHS and CAMHS have led to a reduction of commissioned beds in some areas, with the money redeployed to fund community provision. By looking at the outcomes of these types of initiatives, commissioners will be able to consider the most appropriate next step for their area.

### **Adolescent Multi-agency Support Service AMASS (Islington)**

AMASS provides an Intensive Community Outreach Network (ICON) model of service for those young people aged 10-16 years who are at risk of social exclusion, on the edge of being taken into local authority care or at risk of foster placement disruption. Typically they are children/young people exhibiting extremely challenging behaviour, which is persistent (i.e. weekly) and enduring (6 months or longer), often violent and aggressive. They may be at a significant risk of harm to themselves or to others, eg self harming, substance misuse, sexual exploitation, absconding, offending.

Although the aim of AMASS is not specifically to reduce inpatient admissions, the project attempts to find ways of helping young people who would be vulnerable to mental ill-health and hospitalisation.

The evidence base relating to this client group shows that interventions need to:

- involve parents (the families AMASS works with have a degree of need which means that they have an allocated social worker and with whom targeted and universal provisions have been tried)
- be very flexibly delivered
- address multiple aspects of a young person's life, such as education, leisure, and friendships
- be sufficiently intensive to effect change.

Families are selected on the basis of need for intensive input, of escalating difficulties, and non-engagement with other professionals. The intensive intervention lasts for approximately six months (followed by six months maintenance) and families receive two joint home-visits a week by their allocated Social Worker and AMASS ICON worker, with additional telephone support between visits and a multi-agency wrap around team to tackle areas of exclusion and non-engagement with

the young person, e.g. education, positive activities. The model uses behavioural and systemic methods to support parental authority within the family. A tightly focused, goal-directed approach is used in which parents and young people set longer-term overall goals which they attempt to achieve through tackling weekly goals relating to the problem behaviour.

Evaluation of the work suggests a reduction of institutional placements as well as providing an effective model of care, at a reduced cost.

### **Integrating the joint strategy and Local Area Agreements**

Any joint strategic plans developed by commissioners of AMHS and CAMHS will need to be included in the plans of the PCT, Children's Trust and local authority for the coming year, so that appropriate resources may be identified or allocated. It may also be helpful to reinforce the importance of the strategy by including it in the Local Area Agreement (LAA), so that all strategic partners are working to a common goal and considering young people's mental health services in their broadest sense.

#### **Adolescent Assertive Outreach model**

(South West London /St George's MH Trust)

This is an integrated highly specialist service consisting of an outreach team, 8 bed acute unit and day programme, for adolescents 12-17, (but patients are mainly 15 to 17 year olds) presenting with serious mental illness, where inpatient admission is considered. It aims to avoid or reduce inpatient care wherever possible through the use of intensive outreach. It is commissioned by five South West London Boroughs through a consortium with a lead PCT, where all share the risk but with the stability of committed funds.

Although the team does have access to beds, (eg for part week stays, crisis admission, day programme) most of the work is undertaken in homes, as well as clinics, schools and environments where young people feel comfortable such as parks.

The outcomes include highly dependent patients being managed with little use of Psychiatric Intensive Care Units; few 'blocked' beds; no private beds used; admissions to adult beds are rare; length of stay in CAMHS beds for most patients is less than three months.

## Questions for commissioners

Have neighbouring PCTs got similar issues regarding the provision of inpatient beds?

**Have neighbouring areas developed innovative solutions from which you can learn – or could you commission extended services from neighbouring areas if the model is what you are looking for?**

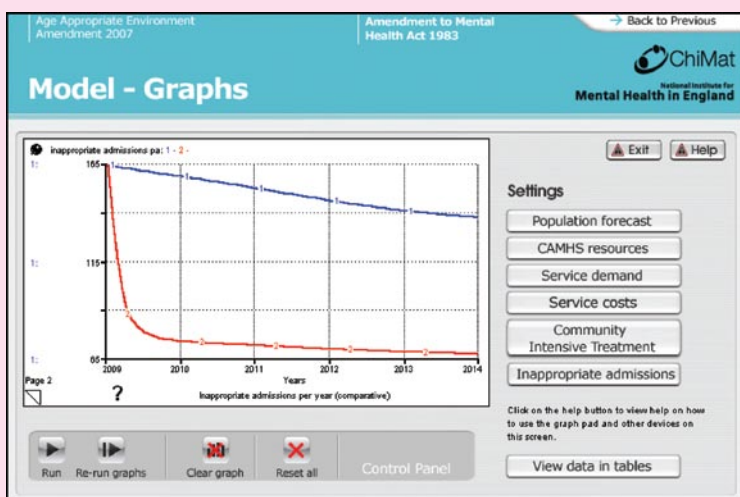
If your area is moving towards a specialist commissioning model, how close are relationships with the specialist commissioning team and local commissioners of community services?

**Is there a joint working group of the LIT and CAMHS partnership looking at this issue?**

Are you considering this issue early enough in the planning cycle? If you plan to reconfigure services this takes time particularly if you are looking to recruit new staff and new teams.

## The Age-Appropriate Services System Dynamic Planning Tool

The National Institute for Mental Health in England (NIMHE)'s Children and Young People's Programme has developed a System Modelling Tool to assist local areas to plan for the new duty to provide an age-appropriate environment. It is designed to support commissioners and providers. AMHS and CAMHS commissioners (and service providers) can use the model to map existing care pathways and patient flows, including economic information. The model can act as a catalyst for debate within planning systems to determine the best local solution to problems identified in care pathway mapping support commissioners and providers to test possible changes and improvements and predict possible outcomes.



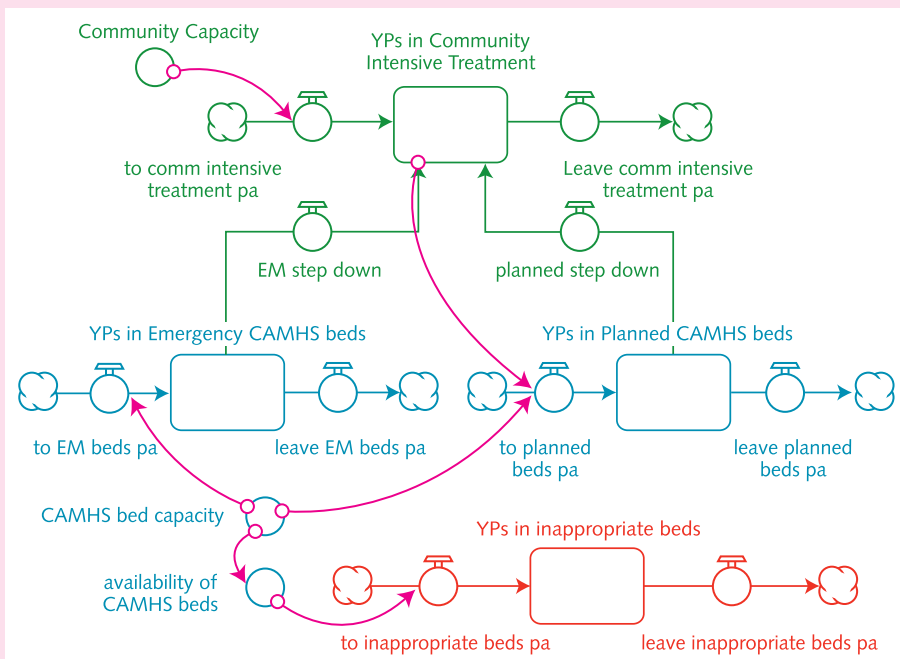
The model enables the user to recreate the problem performance of the pathways in place (such as the inability to admit a young person in a crisis and inappropriate admissions), and then adjust and change the service model to seek improvement.

The model contains three specimen scenarios which illustrate the sort of issues areas are facing:

- A local area with CAMHS beds which limited ability to admit in an emergency – what happens to stays on adult wards if some planned beds are switched to take emergency admissions?
- A local area with emergency beds and planned beds but no community intensive treatment team for young people – what happens if a community intensive treatment team is put in place?
- A local area with no inpatient capacity for 16–18 year olds, which is using adult wards due to lack of capacity – how many extra beds would be required to prevent inappropriate admissions?

The model can be run via the internet, or downloaded and saved from tools and data section at [www.chimat.org.uk](http://www.chimat.org.uk)

### A simplified schematic of the underlying structure of the model :



## Frequently Asked Questions

**We have some CAMHS beds, but when they are full we send young people to CAMHS beds out of the area. We are thinking about altering one of our adult wards to allow us to put young people on the adult ward rather than send them out of area. Is this acceptable?**

The Government has made a commitment that section 31(3) of the Mental Health Act 2007 will be commenced in England by April 2010. Section 31(3) adds a new section 131A to the Mental Health Act 1983 which places a duty on hospital managers to ensure that under 18 year olds admitted to hospital for mental health treatment are placed in an environment suitable for their age, subject to their needs. In practice, this means under 18s should be in a CAMHS facility unless an adult ward would be a more appropriate environment for them or if the need is so great and no CAMHS bed is available, then for reasons of safety you need to admit to an adult ward. These emergency placements must be moved to a bed in an appropriate environment as soon as possible.

Generally it would not be acceptable to place 16 and 17 year old patients (there is an absolute prohibition on under 16s) on an adapted adult ward as a matter of routine for a protracted period of time, rather than sending them out of area to a CAMHS bed. If, however, you are putting young people on to the adult wards when they are in great need when you don't have a CAMHS bed available, and then moving them as soon as possible, then this is acceptable. However, even in an emergency a young person must be safe.

**Adult services in my trust are taking a zero tolerance view of young people on adult wards, but there are no emergency CAMHS beds available. Is this legal? Who should I consult to resolve this?**

Under the Children Act 2004 organisations have a duty to safeguard children and young people. This requires commissioners and providers to plan together to meet the needs of children and young people in their area. The wording of section 131A of the Mental Health Act 1983 will allow young people to be admitted to an environment which would not normally be considered suitable for someone their age if the need is overriding. In an emergency, the first imperative is to safeguard the young person and under some circumstances this might, for 16 and 17 year olds, include a brief stay on an adult ward. This is a matter for your local CAMHS partnership and Local Mental Health Board to resolve, and should involve both commissioners and providers. Under 16s should never be admitted to adult psychiatric wards, and local protocols should be in place to prevent this from happening.

**My area is thinking about developing a unit for young adults aged 16–20. Would such a unit meet the requirement to provide an Age-Appropriate Environment ?**

Deciding how to ensure the duty is met, in section 131A of the Mental Health Act 1983, to provide an age-appropriate environment for under 18s is a matter for local resolution. Ministers have given a commitment to commence that section in England by April 2010. The duty to ensure that each individual young person is in an environment which is suitable for their age (subject to need) is with the hospital managers (ie the trust or other body which runs the hospital), with guidance from a suitable specialist. A ward or unit specifically designed for young adults 16–20 which meets the requirements of the Code of Practice may well be appropriate for some of the young people in the area but may not meet the needs of every young person – so as a result of the assessment, it may not be possible to place an individual in the young adult’s unit or may require the trust to look at the case mix and move some of the over 18s off the ward or place an individual elsewhere. Hospital managers and assessing clinicians would still need to ensure that the admission to the young adults unit was appropriate in each case, and not assume blanket compliance. However, it would not be acceptable to place an under 16 year old on a young adults ward as there is an absolute prohibition on placing under 16s with adults.

**My area is thinking about developing a ‘whole life’ unit for Eating Disorders, starting at 14. Is this acceptable for under 18 year olds?**

The Government has prohibited the placing of under 16s with adults (those over 18 years old), so a ‘whole life’ model starting at 14 would be in breach of government policy. For over 16s, the same approach applies as in the previous question. If the ward or unit meets the requirements of the Code of Practice it may well be appropriate for some of the young people in the area but may not meet the needs of every young person – so as a result of the assessment, it may not be possible to place an individual in the specialist unit. Hospital managers and assessing clinicians would still need to ensure that the admission to the specialist unit was appropriate in each case, and not assume blanket compliance.

**Is it true that only a CAMHS specialist should place an under 18 year old under detention under the Mental Health Act?**

The legal requirements for detaining any patient under the Mental Health Act are the same for any patient of any age. However, the Code of Practice makes it clear in Chapter 36.20 that it is good practice to involve a CAMHS specialist wherever possible.

**Can an under 18 year old be eligible for Section 117 aftercare?**

Yes.

# Action Checklist

Action Checklist	No	Partial	Yes	Action Agreed? By when and whom
A joint working group of the LIT and CAMHS partnership is in place to consider the new duty.				
Local and specialist commissioning teams share planning to ensure the new duty is met.				
Plans to meet the new duty are built into the planning cycle.				
An up to date needs assessment with figures for those currently in the services, including presenting problems, diagnoses, treatment and outcomes is available.				
A clinical caseload analysis has been carried out to consider whether some admissions could have been prevented, or the length of stay reduced, if a dedicated service for young people had been available.				
The resources used on inappropriate placements, whether on adult wards with high-agency costs or on high-cost spot purchasing of out-of-area placements in independent inpatient units, or through the placement of young people with mental illness on paediatric wards are recorded and known.				
Assessment protocols are in place to ensure every under 18 year old is assessed appropriately.				
Arrangements are in place for out of hours assessments.				

Action Checklist	No	Partial	Yes	Action Agreed? By when and whom
Young people are not admitted inappropriately to adult wards.				
The inpatient provision in your area for under 18 year olds is clearly recorded.				
Arrangements have been made to meet the physical, therapeutic and social needs of under 18s in all inpatient environments, planned and emergency, NHS and independent sector.				
Information provided to Director of Children's Services and providers of out of hours rota such as the Adult Team or Approved Mental Health Practitioner team includes information about bed availability, protocols for the admission of under 16s to prevent any admission to adult wards and protocols for 16 and 17 year olds.				
Monitoring of all providers in place, including Foundation Trusts and protocols agreed regarding reporting of any incidents of under 16s on adult psychiatric wards to your Strategic Health Authority as a Serious Untoward Incident, with clear action plans which demonstrate what steps have been taken to prevent recurrence.				
Arrangements are in place for quick transfer to an appropriate placement when an under 18 year old is placed temporarily on an adult ward where there is an overriding need to admit and no CAMHS bed is available.				

Action Checklist	No	Partial	Yes	Action Agreed? By when and whom
The Local Safeguarding Children's Board is aware of and satisfied with the measures in place.				
The Strategic Health Authority is aware of your plans.				
There are written quality standards for adult psychiatric wards in your contract for occasions when 16 and 17 year olds are admitted to adult wards.				
Clear care pathways are in place for under 18 year olds in an emergency.				
The use of paediatric wards or police stations used as an alternative to adult psychiatric wards is recorded and reviewed.				
Clear care pathways are in place for planned admissions of under 18 year olds.				
The cost of emergency, planned, NHS and independent beds is monitored.				
The use of out of area placements is monitored.				
Access by families and friends to young people is taken into consideration in placing young people out of area.				
The average length of stay for local placements versus distant placements is monitored, including any difference in how young people engage with local services if they have been placed far from home, and what effect this might have on readmission.				

Action Checklist	No	Partial	Yes	Action Agreed? By when and whom
The views of children, young people and their families about the services you are offering are sought.				
Young service users and their families are involved in planning future developments in services.				
Children, young people and their families know how to get help in an emergency.				
Children, young people and families receive feedback on how their views about services have been used.				
Good transition protocols are in place.				
Young people who were referred to mental health services but did not attend appointments or who refused the service are asked why they did not engage and any specific issues fed into planning.				
Good practice and shared problems are explored with neighbouring areas.				
Where specialist commissioning is in place, there are close links between specialist commissioning and local commissioners and community services.				

# Annex 1

## The fundamental principles in the Code of Practice<sup>68</sup>

Chapter 1 of the Code of Practice provides the following set of guiding principles which should be considered when making decisions about a course of action under the Act.

### Purpose principle

Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and well-being (mental and physical) of patients, promoting their recovery and protecting other people from harm.

### Least restriction principle

People taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.

### Respect principle

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability. They must consider the patient's views, wishes and feelings (whether expressed at the time or in advance), so far as they are reasonably ascertainable, and follow those wishes wherever practicable and consistent with the purpose of the decision. There must be no unlawful discrimination.

### Participation principle

Patients must be given the opportunity to be involved, as far as is practicable in the circumstances, in planning, developing and reviewing their own treatment and care to help ensure that it is delivered in a way that is as appropriate and effective for them as possible. The involvement of carers, family members and other people who have an interest in the patient's welfare should be encouraged (unless there are particular reasons to the contrary) and their views taken seriously.

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68. Department of Health (2008). Op. cit.

**Effectiveness, efficiency and equity principle**

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective, efficient and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

The Code of Practice gives the following guidance on the use of the principles:

**Using the principles**

All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.<sup>69</sup>

The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

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69. Human Rights Act 1998. [www.opsi.gov.uk/acts/acts1998/ukpga\\_19980042\\_en\\_1](http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1)

## Annex 2

### Other legislation and policy context

The 2007 amendments to the Mental Health Act 1983 strengthen the previous policy and legislative commitment to ensure children and young people are in a safe and appropriate environment.<sup>70</sup>

All recent policy and guidance on mental health services stresses the need for closer working with partners, with other organisations, both statutory and non-statutory, and within organisations across client group boundaries.

The National Service Frameworks in particular emphasise the benefits of closer working and suggest the development of integrated services, taking a broader view of the needs of individuals, supported by good data and researched evidence. In addition, policy and guidance clearly state that the safety of children and young people is paramount and the need for ensuring that they receive treatment that is appropriate for their age group, within an environment most conducive to their recovery.

#### **National Service Framework for Mental Health (NSFMH) for adults of working age<sup>71</sup>**

The aims of the NSFMH are to:

- improve the quality of services
- remove the wide and unacceptable variations in provision
- set national standards and define models for promoting mental health and treating mental illness
- put in place programmes to support local delivery
- establish milestones and specific high-level indicators against which to measure progress within agreed timescales.

The NSFMH covers a variety of activities which are delivered not only by health but also by partner organisations such as local authorities and the independent sector and it marks the beginning of the development of the means to undertake systematic reviews of services and to be able to compare these across the country, with a view to improving services and removing inequality.

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70. Mental Health Act 2007. Op. cit.

71. Department of Health (1999). Op. cit.

The NSFMH is clear about the position of young people on adult wards, stating that if a bed in an adolescent unit could not be located for a young person, but admission is essential for the safety and welfare of the service user or others, then care may be provided on an adult ward for a short period. As a contingency measure, NHS trusts are advised to identify wards or settings that would be better suited to meet the needs of young people. The NSF states that a protocol must be agreed between the child and adolescent mental health services, and adult services, setting out procedures that safeguard the patient's safety and dignity.

The NSF recommends the use of early intervention in crises and emergencies, for the safety of both the public and the patient stating that timely access to services reducing delays in assessment, treatment and care can also reduce the risk of relapse and potential harm to the service user and others.

It notes that to achieve standards four and five (Effective services for people with severe mental illness) requires local health and social care communities to prioritise the needs of those with severe mental illness in local mental health strategies, and that systems needed to be developed to ensure integrated systems for assessment and care planning; care delivery and review; engaging service users; responding to crisis; and ensuring timely access to either home treatment, hospital care or an alternative place for those who need it.

The National Service Framework for Mental Health comes to an end in 2009 and will be followed by **New Horizons**, a new strategy that will promote good mental health and well-being, while improving services for people who have mental health problems.<sup>72</sup>

### **National Service Framework for Children, Young People and Maternity Services<sup>73</sup>**

Standard 9 of the National Service Framework (NSF), in the section on the Mental Health and Psychological Well-Being of Children and Young People states that *'All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high services to ensure effective assessment, treatment and support, for them and their families.'*<sup>74</sup>

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72. Department of Health (2009) A new vision for mental health and wellbeing. [www.dh.gov.uk/en/News/Recentstories/DH\\_097701](http://www.dh.gov.uk/en/News/Recentstories/DH_097701)

73. Department for Education & Skills, & Department of Health (2004). Op. cit.

74. Department of Health (2004). The mental health and psychological well-being of children and young people. Standard nine of the National Service Framework for children, young people and maternity services. [www.dh.gov.uk/assetRoot/04/09/05/60/04090560.pdf](http://www.dh.gov.uk/assetRoot/04/09/05/60/04090560.pdf)

The NSF recommends that the care of seriously disturbed children and young people should be provided by a network of services that includes inpatient, residential, day patient, in and out reach and therapeutic foster care, closely linked to local community CAMHS.

The NSF Marker of Good Practice for CAMHS beds states that there should be sufficient numbers of beds matched to need for each locality; i.e. patients who should be admitted on clinical grounds are not refused due to limitation of resources such as bed availability. Where a child or young person needs to be placed in an inpatient unit, every effort should be made to find a place that is close to home, so that contact with the family can be maintained.

The NSF also states that when children and young people are discharged from inpatient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the 'care programme approach'.

Services and accommodation for 16 and 17 year olds are included in the Proxy Indicators or Vital Signs used to measure a PCT and a Local Authority's progression to comprehensive CAMHS.<sup>75</sup>

### **Safeguarding children**

The 2008 report on Safeguarding Children noted that most areas consider that they are making progress towards comprehensive provision of CAMHS, that service provision is increasingly appropriate to the age of the children concerned and children's centres are helping to promote mental and emotional health, but there remain significant shortcomings, including a shortage of suitable hospital beds for children in some areas and long waiting times for access to services.<sup>76</sup> It also found there were still considerable weaknesses in transition arrangements for young people moving into adult services, which reflected the position in 2005.

### **Further guidance**

The latest Public Service Agreement emphasises the need to improve the mental health and psychological well-being of all children and young people.<sup>77</sup>

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75. Department of Health (2008c). Operational plans 2008/09-2010/11: national planning guidance and 'vital signs'. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_082542](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082542)

76. Ofsted (2008). Safeguarding children: the third joint chief inspectors' report on arrangements to safeguard children 2008. [www.safeguardingchildren.org.uk/Safeguarding-Children/2008-report](http://www.safeguardingchildren.org.uk/Safeguarding-Children/2008-report)

77. H M Government (2008). Op. cit.

**The Children's Plan (2008)**<sup>78</sup> again makes clear that effective and responsive mental health services are vital to support children and young people with emerging or existing mental health conditions.

**The NHS Operating Framework (2007)**<sup>79</sup> is clear that PCTs should work with local authorities to ensure that children's emotional health and well being needs are assessed and that action to address these is included in PCT plans, Local Area Agreements and NHS contracts as appropriate. It cites Every Child Matters and the Children's Plan as the context of this joint working.

**Children and young people in mind: the final report of the National CAMHS Review**<sup>80</sup> The recently published Review (November 2008) has a number of recommendations which are relevant to issues surrounding the implementation of the Age-Appropriate Environment amendment, many of which are highlighted in the body of the report.

The Review's recommendations stress the need for integrated, evidence-based and outcome focused service commissioning, planning and delivery. It also emphasises the need for workforce and curriculum development, and for regional support mechanisms to be streamlined and coherent, balancing performance information and service improvement.

The implementation of the recommendations should lead to closer working relationships between SHAs, Government Offices and service improvement/field workforce teams and to a strengthening of Children's Trusts. There should also be support for local services, easier to access and easier to understand, with an emphasis on evidence, outcomes and evaluation.

There are very strong implications for improvements in the capacity of the workforce, both in numbers and in skills, and there is an emphasis on commissioning.

Additionally, the report states that there should be a 'shared development of language used to describe services, so that all services can understand they are part of the comprehensive range of provision to address mental health and psychological well-being' which should improve consistency and promote greater co-operation and co-ordination.

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78. Department for Children Schools and Families (2007). The children's plan: building brighter futures. [www.dcsf.gov.uk/childrensplan/downloads/The\\_Childrens\\_Plan.pdf](http://www.dcsf.gov.uk/childrensplan/downloads/The_Childrens_Plan.pdf)

79. Department of Health (2007). The NHS in England: the operating framework for 2008/09. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_081094](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094)

80. Children and young people in mind: the final report of the National CAMHS Review (2008). Op. cit.

## **Securing better health for children and young people through world class commissioning: a guide to support delivery of Healthy Lives, Brighter Futures: the strategy for children and young people's health<sup>81</sup>**

This guide to commissioning supports commissioners in delivering the vision set out in the accompanying child health strategy, Healthy Lives, Brighter Futures by using world class commissioning competencies and aligning the commissioning cycles across agencies.

## **World Class Commissioning: Improving children's emotional health and psychological well-being** looks at the wider issue of commissioning services for children and young people of all ages and all level of mental health need.<sup>82</sup>

It also considers how this can be undertaken within the context of the Commissioning Framework for Health and Well Being<sup>83</sup> and World Class Commissioning,<sup>84</sup> and will give commissioners further guidance on wider issues such as prevention and on workforce reorganisation.

## **Children Act 2004<sup>85</sup>**

The Children Act 2004 provides the legislative spine for the government's Every Child Matters: Change for Children agenda, and for developing more effective and accessible services focused around the needs of children, young people and families.

Where any child or young person aged under 18 is accommodated on an adult mental health ward, providers and commissioners must have measures in place to meet their statutory obligations and their safeguarding requirements, as set out in section 11 of the Children Act 2004. The key requirements are that:

- beds in a single-sex area have been specifically set aside for use by children or young people
- staff are Criminal Record Bureau (CRB) checked and have support and training available to them from CAMHS professionals
- the Local Safeguarding Children's Board is satisfied with the measures in place

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81. Department of Health (2009). Op. cit.

82. Moss, J. (2008). Op. cit.

83. Commissioning Framework for Health & Wellbeing. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_072604](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072604)

84. World Class Commissioning. [www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm](http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm)

85. Children Act 2004. Op. cit.

- using the Care Programme Approach, adult mental health and child and adolescent mental health staff work closely together to plan the care, discharge and after-care
- educational, recreational facilities and advocates who have been trained to work with children and young people and in mental health legislation, are available
- local authority and voluntary social care, vocational and housing services are part of the network supporting the child or young person on the adult mental health ward.

### **United Nations Convention on the Rights of the Child<sup>86</sup>**

The UNCRC sets out a range of civil and political, social, economic and cultural rights that apply to all individuals under the age of 18. Although it is not part of UK domestic law, by ratifying the UNCRC, the UK Government has agreed to do everything it can to take steps to implement it.

Furthermore, our national courts and the European Court of Human Rights can take the UNCRC into consideration when adjudicating on cases relating to children and young people.

The UNCRC seeks to achieve a balance between respecting the responsibilities of parents to make decisions on behalf, and in the best interests, of their child and enabling children and young people to exercise their rights. For example:

Two core principles of the UNCRC are that the best interests of the child are a primary consideration in all actions concerning children (Article 3) and ensuring respect for the views of the child (Article 12).

Article 37 states

*Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.*

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86. UNICEF (1989). Op. cit.

# Annex 3

## Resources section and further reading

### **Children and Adolescent Mental Health Services Review**

Children and Young People in mind: The final report of the National CAMHS Review 2008: [www.dcsf.gov.uk/CAMHSreview/](http://www.dcsf.gov.uk/CAMHSreview/)

### **Children and Young People**

Department for Education and Skills, Care Matters: Time for Change, June 2007: [www.dcsf.gov.uk/publications/timeforchange/docs/timeforchange.pdf](http://www.dcsf.gov.uk/publications/timeforchange/docs/timeforchange.pdf)

Every Child Matters: Change for Children: a range of publications are available at: [www.everychildmatters.gov.uk/](http://www.everychildmatters.gov.uk/)

Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, April 2006  
[www.everychildmatters.gov.uk/workingtogether/](http://www.everychildmatters.gov.uk/workingtogether/)

Department for Children, Schools and Families., The Children Act 1989 Guidance and Regulations. Volume 1 Court Orders, London:TSO 2008  
[www.dcsf.gov.uk/localauthorities/\\_documents/content/childrensactguidance.pdf](http://www.dcsf.gov.uk/localauthorities/_documents/content/childrensactguidance.pdf)

Healthy lives, brighter futures – The strategy for children and young people's health. London, TSO 2009 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_094400](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094400)

### **Human Rights**

Equality and human rights (Department of Health):  
[www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/index.htm](http://www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/index.htm)

General information on human rights (Ministry of Justice):  
[www.justice.gov.uk/whatwedo/humanrights.htm](http://www.justice.gov.uk/whatwedo/humanrights.htm)

UNICEF, Implementation Handbook for the Convention on the Rights of the Child, 3rd rev. ed edition (27 Feb 2008)

### **Mental Health Act 1983 (as amended)**

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